

AD-A055 173

SAM HOUSTON STATE UNIV HUNTSVILLE TEX INST OF CONTEM--ETC F/G 5/11
AN EXAMINATION OF SOME INTER-DISCIPLINARY RELATIONSHIPS BETWEEN--ETC(U)
MAY 77 J T MARTIN

UNCLASSIFIED

1 OF 2
AD
A055173

NL



FOR FURTHER TRANSMISSION

①

AN EXAMINATION OF SOME INTER-DISCIPLINARY RELATIONSHIPS
BETWEEN THE PROFESSIONALS INVOLVED IN CHILD ABUSE AND
NEGLECT CASE MANAGEMENT IN THE MILITARY COMMUNITY

by

John Thomas Martin, III

A THESIS

Approved:

DDC
RECEIVED
MAR 6 1978
REGULATED

Q7 A

Billy W. Bramlett
Billy W. Bramlett, Ph.D.

George G. Killinger
George G. Killinger, Ph.D.

Pauline Loveless
Pauline Loveless, Ph.D.

Approved:

DISTRIBUTION STATEMENT A

Approved for public release;
Distribution Unlimited

Dean of Graduate School

AD A 055173

AD No. _____
DDC FILE COPY

alt.

ABSTRACT

Martin, John Thomas III, An Examination of Some Inter-Disciplinary Relationships Between the Professionals Involved in Child Abuse and Neglect Case Management in the Military Community

Purpose

The primary purpose of the study was to identify some of the inter-disciplinary problems involved when a multidisciplinary team concept is utilized to attack the specific medical social problem posed by child abuse and neglect case management in the military community. The secondary purpose was to examine local, Army installation's implementation of the Army Child Advocacy Program (ACAP) which went into effect Army-wide on February 1, 1976. Special attention was afforded the Child Protection Case Management Team (CPCMT) concept included as a part of the ACAP.

Methods

Information for this study was obtained from: (1) an examination of pertinent Army regulations; (2) a review of pertinent literature available; (3) an examination of responses to a questionnaire specifically designed to survey the personal opinions of military community professionals (those people with potential to act in some official capacity in child abuse and neglect case management); and (4) a considerable number of informal

interviews with military community professionals and policy makers.

Findings

The following facts were determined from the information and evidence assembled during the study.

The Army was late to provide any sort of policy or standard guidance in the area of child advocacy. Consequently, when implementation of an Army-wide ACAP was directed, it was in immediate competition with a variety of local programs that had been in operation up to several years. The result is less than satisfactory compliance with the ACAP. Specifically in the area of child abuse and neglect case management, the ACAP formalized CPCMT procedures based on the same model that most local case management programs had adopted. While program competition was not significant, new roles or dimensions were added for which the local professional practitioners were neither prepared nor equipped to fulfill. The result is some degree of confusion and frustration. Problem awareness is extremely high.

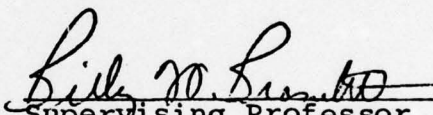
Service delivery professionals expressed a wide range of opinions that coincide less than twenty-five percent of the time with Army imposed guidelines and procedures. Much evidence points to the lack of effective interdisciplinary communication in the subject area with

accompanying feelings of resentment and helplessness. Cooperation among case management participants was found to be adequate, but areas for improvements were noted.

Professional training in child abuse and neglect was determined to be sorely lacking.

Professionals were found to be simultaneously highly opinionated and critical of disciplines other than their own and not free with suggestions to improve the system.

A top-level, Department of the Army push was determined to be needed to have the spirit and the letter of the Army Child Advocacy Program become a reality.


Supervising Professor

ACKNOWLEDGEMENTS

I wish to express my appreciation to my thesis committee chairman, Dr. Billy W. Bramlett, for permitting me an entirely free hand in every aspect of my endeavor.

To Dr. Pauline Loveless, I owe special acknowledgment for the absolutely unselfish manner in which she shared her library; knowledge; enthusiasm; time; and criticism with me.

I am indebted to Lieutenant Colonel Jerry L. McKain, Chief Social Work Consultant, U.S. Army Health Services Command for opening his files to me and for sharing his thoughts with me. The result of our initial meeting was not merely academic direction, but a specific topic to pursue.

I also wish to express my appreciation to Dr. George G. Killinger, Director of the Institute of Contemporary Corrections and the Behavioral Sciences, and the United States Army; without either institution my entire graduate school endeavor would not have been possible.

This cataloging of acknowledgements would not be complete without a most sincere thank you to my wife, Lauralee. Her love, understanding and encouragement have made possible not only this thesis, but my dedication to my career in military law enforcement.

TABLE OF CONTENTS

	PAGE
ABSTRACT.....	iii
ACKNOWLEDGEMENT.....	vi
LIST OF TABLES.....	vii
CHAPTER	
I. INTRODUCTION.....	1
Problem and Purpose.....	2
Definition of Terms.....	3
Design of This Study and Basic Issues.....	4
Scope of This Study.....	6
II. REVIEW OF THE LITERATURE AND PARALLEL HISTORICAL DEVELOPMENT.....	9
III. METHODOLOGY.....	29
Description of Study Setting.....	29
Sample Criteria and Description.....	34
IV. RESULTS OF THE SURVEY.....	38
Awareness.....	39
Mutuality of Knowledge.....	43
Sequence of Contact.....	49
Teamwork.....	50
Grass Roots Ideas.....	55
V. INTERPRETATIONS, IMPLICATIONS AND RECOMMENDA- TIONS.....	64
FOOTNOTES.....	92
BIBLIOGRAPHY.....	98

PAGE

APPENDIXES

Appendix A. Army Regulation No. 600-48, The Army Child Advocacy Program (ACAP).....	105
Appendix B. Common Resources.....	117
Appendix C. Survey Questionnaire.....	120
VITA.....	128

LIST OF TABLES

TABLE	PAGE
1. Characteristics of Survey Respondents.....	37
2. Primary Selections of Survey Respondents for Advice/Assistance.....	50
3. Teamwork Responses of Survey Participants.....	52
4. Respondent's Selections as Best Qualified For Overall Child Abuse and Neglect Case Management Responsibility.....	56

CHAPTER I

INTRODUCTION

The most up-to-date listing of financial grants awarded by the Office of Child Development in the United States Department of Health, Education, and Welfare lists sixty-nine on-going (until at least mid-1977) projects in the area of child abuse and neglect.

Projects in this goal area are designed to increase knowledge about the causes, nature, extent, consequences, prevention, identification, and treatment of child abuse and neglect, and to improve services to abused and neglected children [Rackly, 1976, p. 24].

Each of these projects involves service delivery demonstrations. Forty-two grants (totalling over eight and one quarter million dollars out of a grand total of just over thirteen million dollars) were awarded to activities which implicitly or explicitly stated as part of their project goals the "coordination of abuse/neglect services"; the "mobilization of a coordinated system"; to "effect a cooperative network of multidisciplinary professionals and lay people and a coordinated network of services"; or to "design models for coordination." There is apparently a rather formidable problem in the specific area of multidisciplinary coordination since over sixty percent of the projects and over sixty-three percent of the federal dollars address the subject. With the corresponding,

conspicuous lack of specific literature, one cannot help but wonder if the myriad of federally funded demonstration project administrators know exactly what problems exist, which obstacles must be overcome in a coordinated team approach to child abuse and neglect, and what specific efforts will overcome this lack of coordination on a lasting basis. Hopefully, this particular study will begin to fill the void.

Problem and Purpose

The primary purpose of this study is to identify some of the interdisciplinary problems (not legal or jurisdictional problems) involved when a multidisciplinary team concept is utilized to attack a specific medical social problem in the military community. Presently in the area of child abuse and neglect case management, no single profession or discipline can state with any degree of confidence that it has the solution to the problem. The alternatives that are proposed vary greatly, but a realistic approach to the problem that does not cross disciplinary lines does not exist.

The United States Army, at different times; in different places; and in different ways, recognized the existence of child abuse and neglect within the military community. Efforts toward problem solving were extremely fragmented. The success of any given program--or even

the existence of a child abuse and neglect program on the local level--depended solely on the personal efforts of concerned individuals in the absence of any Army-wide policy or program. It was not until February 1, 1976, that the Army Child Advocacy Program (ACAP) went into effect. The ACAP is still too new, in this writer's opinion, to attempt a fair evaluation of its effects on an Army-wide basis. But it is not too soon to examine its local operationalization. That is the secondary purpose of this study.

Definition of Terms

"Professional" is used throughout the study not in the sense of occupational status, but rather as a synonym for anyone in a position of authority, regardless of discipline, with potential to act in some official capacity in child abuse and neglect case management.

"Case management" refers to any action taken by a professional subsequent to the initial discovery that child abuse and neglect (or suspected child abuse and neglect) has taken place.

"Military community" includes the total military population of a particular Army installation, their families (dependents), and the complete array of military and civilian services, agencies, activities, and institutions available in the geographical area. Except as

noted in later discussion, no distinction in actual residence is implied between on-post or off-post.

"Sponsor" refers to the individual family member who is actually a member of the U.S. Army; other family members are "Dependents."

A concerted effort has been made to avoid unfamiliar and possibly confusing military jargon, terminology, acronyms, and the like. If the civilian reader is the least bit apprehensive about proceeding through this study, the writer recommends the reader first peruse the six-page (269-275) section, "Military Life Style," by John K. Miller found in Helfer and Kempe's Child Abuse and Neglect: The Family and the Community (1976). In it civilian life style parallels are drawn and any military mystic effectively eliminated.

Design of This Study and Basic Issues

Excluding the introductory chapter, this study consists of four major parts: (1) a background for the study; (2) the methodology employed; (3) the results of the survey; and (4) some interpretations, implications, and recommendations.

As part of the background for the study, a review of the literature is presented. It is not a full scale review of published material on child abuse and neglect which is available elsewhere, but rather a particularized

version including only those sources directly concerned with child abuse and neglect in the military community.. General source references are included only insofar as each relates to the interdisciplinary aspects of the study. Paralleling the chronology of the literature is the historical development of child abuse and neglect case management which in the past fifteen years has made a formal transition from personality to policy.

General descriptions of the military communities surveyed as well as specific criteria for inclusion in the survey sample comprises a methodology chapter.

The chapter containing the results of the survey is divided into five substantive categories for discussion. These categories correspond to nine basic issues or specific areas of interdisciplinary relationships identified for investigation. The categories and corresponding basic issues follow:

<u>CATEGORY</u>	<u>BASIC ISSUE</u>
Awareness	Awareness of existing program and requirements
Mutuality of Knowledge	Mutuality of Knowledge
Sequence of Contact	Sequence of Contact
Teamwork	Willingness to accept responsibility Willingness to share responsibility Mutuality of Trust Mutuality of Confidence Mutuality of Respect
Grass Roots Ideas	Previously untapped, grass roots ideas concerning the ACAP.

Following the presentation of the survey results are some possible interpretations that may be attached to those results. Implication of the survey results for the ACAP; military communities; and the military hierarchy follow. An assessment of the ACAP's impact on service delivery in the military community is also offered. To conclude this study, constructive, practical suggestions or recommendations are offered concerning various aspects of identified problems. Broad areas of the ACAP in need of revision are catalogued along with certain specific revisions that are warranted to the Program as it now stands. Corollary recommendations, not concerning the ACAP directly, but in support of it, are also furnished.

Scope of This Study

Although U.S. military communities are located throughout the world, this study focuses on only two: Fort Hood, Texas, and Fort Riley, Kansas. These two installations, selected for a combination of factors--including proximity to the writer, size, mission, and writer familiarity--may be considered to be representative of many similar Army installations. While each individual military community has its unique qualities, the facts of the universal applicability of Army regulations, policies, and programs; a rather standardized, tightly-knit organi-

zational structure; and the centralized military training of professionals combine to suggest the dispersion of military communities is only geographical when a common problem such as child abuse and neglect is examined. The problematic experiences of military communities vary by time, intensity, and reaction thereto--but a commonality of experiences cannot be denied. The assumption is made that the accuracy of this study has not been jeopardized by surveying only two military communities.

Evidence of a shared problem between Fort Hood and Fort Riley is provided by Texas and Kansas state statistics. The Central Texas area that encompasses the Fort Hood military community ranks fourth highest in reported child abuse and neglect incidents per capita; in actual case volume, the area is the leader in the state. The Geary County and Riley County area which includes the Fort Riley military community has the distinction of being the Kansas leader in both statistical categories.¹

CHAPTER II

REVIEW OF THE LITERATURE AND PARALLEL HISTORICAL DEVELOPMENT

Although the discovery of what has generally come to be called child abuse and child neglect has been traced and relatively well documented (Caffey, 1946; Fontana, 1971; Helfer & Kempe, 1968; Wooley & Evans, 1953). Comparatively little literature exists on the subject when an attempt is made to discover its recognition and trace its development within the military (Army) community. The national awareness movement of the last fifteen years, although not directed specifically toward the military community, did not go unnoticed by it. Primarily through the astute observations of members of the Army Medical Corps, specifically pediatricians; members of the Army Nurse Corps, specifically health nurses; and members of the Army Medical Service Corps, specifically social work officers, the military community was seen as possessing a problem worthy of examination.

As early as 1962, concerned social work officers were informally addressing various aspects of the child abuse and neglect problem. Formal programs, such as the Infant and Child Protection Council formed at William Beaumont General Hospital, El Paso, Texas, in 1967, followed. It is evident from a survey conducted in 1970 a number of Army installations designed and operationalized

child abuse and neglect programs in the succeeding years (Arellano). At least twenty-four Army installations in the continental United States had sufficiently recognized the child abuse and neglect problem by 1970, that each had published a regulation concerning it. As Arellano has noted,

This is encouraging from a broad social welfare point of view. From an administrative view point [a situation exists] with little or no uniformity between posts [1970, p. 8].

However, he continues,

There was a hint of some uniformity between posts in that some of them seem to follow the basic model of the Infant and Child Protection Council developed at William Beaumont General Hospital [p. 8].

Welton² (1968) stated that several "responsible officials" including both military and civilian authorities as well as medical and non-medical authorities "met to formulate a plan for handling suspected cases of abuse or neglect of children of Army families [p. 1]." The Infant and Child Protection Council was specifically designed to fill a void. No Army-wide, procedural guidance existed for child abuse and neglect case management; and the need was felt for a "visible, accessible, and responsible structure [p. 3]." The actual intent of the Infant and Child Protection Council "was to prevent further abuse or neglect, if in fact it existed [p. 3]."

Many functions are implied by that goal--among them central reporting, medical treatment, investigation,

multiple referral, family intervention, and child advocacy. The resources and expertise of many different offices and agencies were called for.³ This interdisciplinary effort was determined early in the program to be more successful than previous unstructured approaches to the problem. Nearly each of the agencies comprising the council had formerly tried to manage the problem as a separate entity, but each had not been effective. The interdisciplinary measure within the military community combined "(1) authority to act; (2) skills, techniques and knowledge; and (3) sufficient resources [White, Smith, & Giles, 1968, p. 2]" to effectively manage child abuse and neglect cases.

Whether the Infant and Child Protection Council was formed by accident or design is apparently a conclusion colored by the eyes of the viewer, be he representative of a military or civilian council member component (White, et. al, 1968); nevertheless it represents the earliest documented Army response to the recognition of the problem.

The fact that no single disciplinary approach to managing child abuse and neglect was demonstrated effective paralleled the 1963 finding of Delsordo. Paulsen concluded "A multidisciplinary network of protection needs to be developed in each community... [1966, p. 48];" that is precisely what William Beaumont General Hospital attempted in the military community. The conclusion of an examination of the military community child abuse and neglect situation,

although somewhat superficially accomplished through individual case studies in El Paso, coincided with the more in-depth, empirical research conducted by Kempe and his colleagues in 1962. No single causative factor could be pinpointed, but rather a "problem mosaic", somewhat different in each instance, preceeded the abuse or neglect. Logically, an interdisciplinary approach was mandated.

As other military installations adopted the Infant and Child Protection Council model, it was simultaneously adapted to meet the perceived needs of each local situation. Quite often the council composition was altered to include representatives of the law enforcement and criminal law offices on a post. The presidency of the council generally varied according to who was the highest ranking member irrespective of training, knowledge, ability, position, agency or discipline (Arrellano, 1970; Welton, 1968). The most popular acronym resulting was "SCAN", meaning Suspected Child Abuse and Neglect.

Although SCAN councils were rather prolific, both their existence and their effectiveness were solely dependent upon the personalities--again usually social work officers--who served as their driving force. Program titles, statements of purpose and the conceptual model of William Beaumont General Hospital notwithstanding, any similarity between the various operating principles and methods represented by the twenty-four Army installations was

coincidental (Arrellano, 1970). Some installations listed their regulation under the 210-series, general regulations governing the operation of installations; others placed them in the 600-series, dealing with personnel actions and the responsibilities of a military member toward his dependents; still others were to be found in the 40-series, lending credence to the idea that child abuse and neglect was viewed as strictly a medical phenomena (Arrellano, 1970). Installations approached a fifty-fifty affirmative-negative split when queried, on their ability

to remove a child from his home for his own protection Surprisingly, of 13 posts not covered by a child protection regulation, five responded that they were able to remove a child from his home [Arrellano, 1970, p. 4].

Discrepancies broaden when one looks at the variety of authorities charged to investigate reported instances of child abuse and neglect and knowledge of and compliance with state reporting statutes in 1970 (Arrellano).

Recognizing the nearly total void of empirical data concerning Army child abuse and neglect, Sattin and Miller in 1970, began publishing information learned from nearly three years of study in the El Paso-Fort Bliss-William Beaumont General Hospital military community. Ecologically speaking, it was learned

that child abuse cases were more likely to occur in the 'Dyer Street' section of El Paso and that they were more likely to live in this area than other military

families. ... prior personality variables and/or financial or other environmental stresses were responsible was offered [p. 8]

in explanation of the notable residence patterns of child abuse cases when compared to non-abusing military families.

In 1971, Reister self-admittedly failed in his attempt to profile a "typical" abused child and his parents, but he did compile and publish detailed data on severe cases seen at Letterman General Hospital, San Francisco, California. Reister firmly advocated "the early and extensive application of [a] multidisciplinary approach [p. 3]" developed at his location. He lamented about the high mobility of both military clients and military practitioners:

No physician is likely to be able to afford to rely on his personal charm or skill to guarantee the safety of a child suspected by him of being battered. This is the conclusion of the law and it is supported by the facts locally. The hospital, taken corporately, has the same weaknesses as its physicians, and should conclude that it can not afford to try to safeguard children by reliance on its own fund of skill and prestige. In the military context, especially, such reliance is folly because the movement of both patients and health professionals is brisk [p. 4].

The federal government actively entered the specific child abuse and neglect subject area after many years of general discussions through White House and other top level conferences on youth. Federal legislative efforts culminated in the almost unanimous Congressional passage of Public Law 93-247 which was signed into law on January 31, 1974, by President Nixon. Public Law 93-247, together with

Public Law 93-644 (technical amendments signed into law on January 4, 1975), are known as the Child Abuse Prevention and Treatment Act.

Meanwhile, within the military community, not only were localized studies on-going at several installations (McKain, 1973), but the problem had become recognized far up the military hierarchy, and work was begun on drafting an Army regulation designed to standardize local programs already functioning; establish programs where none existed; and provide for a central, military case register specifically to counter the highly mobile aspect of military life.

Debate about the prevalence, etiology, and seriousness of the child abuse and neglect problem was the order of the day. Miller (1972) insisted that although the problem existed, the incidence was no higher in the military community than in civilian communities, but the appearance of a higher rate was present because of more accurate reporting in a more highly structured and tight-knit society. In other words, child abuse and neglect was more difficult to hide in a military setting than in its civilian counterpart. McKain offered the characteristic of anomie to replace the oft cited mobility as the key ingredient (1969).

Helper irritated some professionals in the military community when he, without citing specific authority, pre-

sented a rather gross military community child abuse and neglect profile to the American Academy of Pediatrics in 1974:

I also didn't realize that the incidence of child abuse and neglect is two to three times as high in the armed forces as it is in civilian life and that the armed forces do not have any kind of policy for dealing with child abuse and neglect. I didn't know that at the Army's Madigan General Hospital in Tacoma, the most common cause of death between the ages of one month and one year is child abuse.

In 1973 Lehman presented a "thesis" to the United States Army Judge Advocate General's School in which he sketched a national, "historical overview" of child abuse and neglect and described the "battered child syndrome." He reported on the "existence of child maltreatment in the military community;" described the present day (1973) handling of cases; and put forth some recommendations.

Lehman, citing statistics obtained from Miller, concluded that there is ample evidence to support the notion that

[The Army] is a reflection of the individuals comprising it, and the problems experienced within [The Army] are manifestation's of difficulties throughout our country [pp. 12-13].

That is, there exists a similar incidence rate of child abuse and neglect in the military and civilian communities.⁴

Miller (1972), Lehman (1973), and Allen (1975) all point out that while there are epidemiological parallels, there are, of necessity, certain etiological differences. There are also major differences in case management. There

is no federal juvenile or family code by which the military community may be guided; there is no military community welfare department. Jurisdictional problems alone are factually mind-boggling; whether or not the practical effect is beyond that which is reasonable is a matter of conjecture. Army lawyers are somewhat preoccupied with the jurisdictional aspects. Some non-legal Army agencies point to the hand-tying effect jurisdictional issues have on them, and Army commanders have been known to rationalize their laissez-faire attitude by citing lack of jurisdiction. The facts are that even where jurisdictional problems are non-existent, the military is extremely reluctant to pursue the matter in the established court system.

Lehman (1973) found only three such cases in the Court Martial Reports. Judge Advocate General opinions speaking to the role of the installation commander include the following wisdom:

the goal of the Commanding General ... where the circumstances warrant, is to seek to establish and preserve an emotionally healthy, nonabusive family, rather (than) to press for prosecution of one or both parents with the risk of destruction of the family unit.⁵

Since the prosecutorial aspects of child abuse and neglect were overshadowed by rehabilitative aspects, one must question the almost religious adherence to the pejorative aspects of the jurisdiction issue. Lehman concluded an Army regulation on the subject was warranted and actually

desired by subordinated commands. This opinion was borne out in fact in early 1974 when only one major command responded negatively to formal inquiry from the Department of the Army about the need for such a regulation.

For some time the Army has had a regulation (AR 600-30, Human Self Development Program) which provided impetus for an installation commander to formally charter "planning units." These units were composed of available experts in a particular area of concern, to assist the commander in confronting some of the challenging problems that emerged particularly during the Vietnam era--racial tension; drug (including alcohol) abuse; dissent; and the like. Clearly, the matter of child abuse and neglect could have fallen under the purview of AR 600-30. Most Army installation commanders never made the connection.

Jurisdictional issues formed the core of the military community child maltreatment problems as discussed by Allen in 1975. She reported that William Beaumont General Hospital, among others, may have violated law in taking certain actions the Infant and Child Protection Council deemed necessary. But, again, the entire jurisdictional question is more problematic than factual. As Allen states,

Although no one has yet contested the authority of the state in maltreatment cases, the possibility of a law suit in the present [1975] jurisdictional confusion creates an additional burden for the child maltreatment team [p. 17].

There have been instances where members of the military community have openly aired the problem at civilian forums, meetings, symposiums, and conferences. The result of such brainstorming has generally been non-productive. The standard format is for the military community representative to explain on-going efforts, request assistance, then reject suggestions because "the military life style" is unique; "military organizational structure is not understood;" or "jurisdictional factors" preclude adoption. This may not be a consciously planned format, but it has recurred. Participants on both the military and civilian sides have sometimes been extremely well-meaning, but remarkably naive.

Two Army installations, Fort Sam Houston, Texas, and Fort Campbell, Kentucky, are presently in the throes of participating in "innovative demonstrations," financed by Department of Health, Education, and Welfare grants to local civilian agencies charged with serving the general public of which the military population forms a large portion. These programs were designed specifically to focus on the needs of the unique military family target group.

The Innovative Demonstrations will seek, within [this] special population to create awareness of the problems of child abuse and neglect, provide a means of identifying the families, deliver necessary services, suggest approaches for improving family life so as to prevent abuse and neglect, coordinate available re-

sources, and consider the unique legal constraints on ... military families. The objectives are to demonstrate new techniques for providing the services that best meet the needs of [this] group (U.S. DHEW, 1975, p. 7).

Each project was to run three and one-half years, and each began in late spring, 1975. Total evaluation of either project will not be possible until the end of 1978.

The United States Army, although by now a decade late in joining the child abuse and neglect legislative arena, published in late 1975 for implementation in early 1976, a basic child abuse and neglect case management program. It is applicable to every Army installation with special provisions for those installations with over 2,000 dependents of assigned military personnel. Army regulation 600-48, Army Child Advocacy Program (ACAP), may be found at Appendix A. A reading of the regulation points up the theme continuation of the earlier sparse guidance, namely a helping attitude toward child abusers and neglectors rather than any type of retribution. The regulation is not without its commentators and critics.

Most practitioners, regardless of discipline, at the installation level welcomed the regulation primarily because it drew local command attention to the local problem and had the effect of saying "Somebody upstairs cares!" Practitioners are pleased at the central registry reporting requirement and the built-in ability to transfer cases between military communities when the sponsor is

transferred with the relatively certain knowledge the gaining authorities will pick up the family prior to another incident of abuse or neglect. Some practitioners on installations where active programs existed prior to 1976, believe the regulation only serves to change terminology.

Granger (1976) catalogues the following criticisms:

... the Army regulation does not detail the power, function, and duties of the Department of the Army agencies (DCSPER and OTSG) [Deputy Chief of Staff for Personnel and Office of The Surgeon General] in regard to providing advocacy, clearinghouse function and information and technical assistance, to involvement in an inter-agency coordinating committee, and to reporting to the Secretary of the Army, annually. OTSG has the responsibility for managing the central registry, but a toll-free number system has to be worked out, a timetable of reporting and verifying has to be evolved, a system of categories of cases ("under investigation," "unfounded," "indicated," or "closed") must emerge

Although structure is provided for an Army Child Advocacy Program Council at posts having at least 2,000 or more military dependents, and a Child Protection Case Management team is created, there is no machinery established to review and approve a local plan for child protective services at the Department of the Army level. In fact, the wording of the regulation suggests endorsement rather than mandating implementation.

The issue of reporting (who is required to report and is allowed to report) is not completely addressed. The penalty for not reporting when required is not covered, and the issue of immunity from liability is also not addressed.

Protective custody is not dealt with, partly because of the problem with jurisdiction. Thus, the hospital commander is

not given the authority to retain custody until the next working day of the appropriate legal or court system.

The structure of the Army Child Advocacy Program Council and the Child Protective Case Management Team is provided but the functions required if they are to be effective are not. The critical functions of such a composite delivery system should include: 1. a research, training, and evaluation function; 2. an identification, reporting and verification function; 3. an assessment function; 4. a crisis and long-range intervention function [pp.6-7].

Some problems have also been expressed by both Granger and a few local practitioners with the definitions used in the regulation. Paragraph 5c states that child abuse and neglect is:

the physical or mental injury, sexual abuse, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened [p. 2].

Although some academicians consider the terms "abuse" and "neglect" to be mutually exclusive or at best, bipolar, the definition was lifted nearly verbatim from Public Law 93-247.

The most recent, and the most extensive, literary treatment of child abuse and neglect in the military community may be found as Chapter 14, "Perspectives on Child Maltreatment in the Military," in Helfer and Kempe's new 1976 text, Child Abuse and Neglect: The Family and the Community. In Chapter 14 Miller highlights the

differences between the standard civilian life style and the standard military life style giving emphasis to the negative aspects as well as the positive aspects that directly contribute to incidents of child abuse and neglect and their subsequent case management. He emphasizes the fact that the military organization does not exist to protect children.

Central to all military life is one theme ... the mission. The mission overrides all other considerations. It may be to win an engagement in war, it may be to train for war, it may be to feed the troops, or it may be to provide medical care. Programs not directly related to military mission accomplishment are incorporated not because they are desirable or a routine part of normal community life; they become justified by how they relate to military effectiveness and mission accomplishment [pp. 273-4].

The singular military concept of command is not ignored by Miller.

The concept of command responsibility transcends formal military structure and carries into family life as well. While military commanders have no direct command authority over family members, they clearly have influence in family lives. They are expected to assist families [p. 272]

in all varieties of problems from family finances to domestic disturbances. "The unit leader walks a tight rope between invasion of privacy and meeting command responsibility [p. 272]."

One major military-civilian difference that is positive in effect is that of determined decision making; and one that is negative in effect is the lack of "citizen

input" and "broad community considerations." The result is that the military from time to time discovers "blind spots" which have previously not been considered. Miller concludes that the area of child abuse and neglect represents one big blind spot; or at best, it is an area replete with so many small blind spots that their cumulative effect is identical. The lack of research within the military community is especially lamented.

The history of child advocacy programs in the military community is traced by Miller (1976) from its grass roots origins through the gradual awakening of top level commanders to the present day disparities between the "sister" services.

Many military child protection programs began as a result of some particularly dramatic or tragic case involving critical injury or death to a child. Usually the shock wave started in the emergency room, passed through the hospital, the military police, and ended up in the post or base command suite Whatever other solutions were proposed, the most effective was that a task force or study group be established to report back with recommendations. Usually this was the start of a child advocacy committee, or a child protection team, which is the basic model most military commands have used in addressing child maltreatment.

These child protection committees are usually made up of key personnel in the military community who are most likely to have some contact with, or influence over, child abuse and neglect

The military system has used [child protection teams] more [than civilian communities] because there is no welfare

department in the military system and because the legal base for child protection in the uniformed services is extremely limited [pp. 282-3].

Regardless of the reasons the military community adopted a multidisciplinary, team approach, this concept appears consistent with the more successful metropolitan hospital approaches as noted by many writers (Doeltz & Adamson, 1968; Silver, Dublin, and Lourie, 1971; Tasem, Dastell, and Goldenberg, 1974; Thomson, Paget, Bates, Mesch, and Putman, 1971). The multidisciplinary team approach is in total agreement with other published practitioners, administrators, and academicians (Besharov, 1975; Cherry & Kubby, 1971; Delsordo, 1963; Fontana, 1971; Fraiberg, 1973; Gelles, 1973; Helfer & Kempe, 1968, 1973, 1976; Johnson & Morse, 1968; Justice & Justice, 1976; Konopka, 1972; Leavitt, 1974; Lourie, 1974; Office of Child Development, 1977; Paulsen, 1966; Steele, 1975; U.S. DHEW, 1975, Weaver, 1976; Zalba, 1966).

Miller (1976) presents his personal formula for child advocacy team membership based on his pre-retirement experiences with the Infant and Child Protection Council. He would limit membership to "around ten to twelve" which is twice that required by the present Army regulation. More important than professional qualifications is the personal interest his members must demonstrate. Miller wants volunteers, not appointees; he wants personnel

delivering services, not merely serving only as consultants or supervisors. In short, he wants members that will cooperate to such a degree that all the standard (and not-so-standard) problems in child abuse and neglect teamwork that could arise will not arise.

Many authorities back the teamwork concept as was noted above; however, even more authorities backing the interdisciplinary concept accompany their endorsement with warnings about problem areas. Besharov (1975) deplores the lack of compassion that accompanies committees, and from the practical side, bemoans the fact that "responsibility is frequently passed from one agency or individual to another [p. 3]." del Valle and Alexander (1967) show how mutual distrust among agencies is difficult to overcome; Eisenberg (1968) explains that disciplinary boundaries work to the disadvantage of the client; Etzioni's organizational text (1969) is replete with examples of disciplinary resentment of interdisciplinary "interference." Galdston (1970) discovered and reported on a tendency for agencies to assume a sort of defensive posture when confronted with an inter-agency, cooperative situation. Agencies tend to define themselves rather rigidly in terms of treatment technique rather than respond to client problems. The result is often a polarization of responses with little forward progress.

Cheney (in Gil, 1973) cites the additional task

of educating team members about each other, a task often overlooked. Heyman (1967) outlined the sociological hierarchy of collaborative relationships in a general hospital; also working in a general hospital setting, Livingstone, Portnoi, Sherry, Rosenheim, and Onesti (1969) stressed the fact that team collaboration is generally a non-teachable technique. The loss of professional identity (autonomy) to the group is handled in differing ways by differing personalities--and are not predictable according to discipline. Lourie and Lourie (1971) warned that definitional problems will result from any inter-agency, cooperative design. Such problems will stem from a client "ownership principle" with the ultimate result of the development of a set of "performance" objectives that pay homage to organizational and professional bounds rather than being client centered as they should. Polier (1975) clearly recognizes the necessity and desirability of a multidisciplinary effort in combating child abuse and neglect and cites the consequences of the alienation from professional responsibility which often occurs.

The fragmentation of professional authority is all too likely to make the determinations easier for each decision-maker by obscuring the consequences of rejection for the child in need of services [p. 358].

Also, the absence of shared standards and lack of effective monitoring are problems to be reckoned with. Pryzwansky (1974) pointed out in a school setting that "organizational

and relational factions" tend to impede collaboration; this comment echos Etzioni (1969), cited above. For some disciplines there is an apparent negative connotation associated with asking for help--regardless of the subject area or magnitude of the problem.

As stated previously, there exists a mere modicum of literature on the subject at hand,⁶ but it must be noted, that which is available parallels the military community's reaction to its discovery of child abuse and neglect; its slow, but steady, expansion of awareness; and the eventual development of Army-wide guidance for case management.

CHAPTER III

METHODOLOGY

Description of Study Setting

Both survey targets, Fort Hood and Fort Riley, prior to the publication of AR 600-48, had recognized the existence of their child abuse and neglect problem and instituted a form of multidisciplinary organization to deal with it. Fort Hood's Child Protection Council (CPC), operating since the late 1960's and Fort Riley's Suspected Child Abuse and Neglect (SCAN) council, operating since 1971, were both patterned after the Infant and Child Protection Council in El Paso.

Child abuse and neglect activity in Fort Hood was formally centered in the military hospital's Social Work Services and pediatric clinic; however, a large amount of ex-officio coordinating appears to have been accomplished through the counseling services of the Army Community Service Agency. After the ACAP went into effect, no appreciable changes were made in either activity or terminology. The CPC is the child protection and case management team (CPCMT); and in fact is also the Fort Hood child advocacy/human resources council. The existing Human Resources Council was not utilized as AR 600-48 pointedly recommends.

The Fort Riley Army Health Nurse, until very

recently, maintained almost exclusive control over child abuse and neglect activities. Pediatric and mental health services of the hospital were employed as necessary, but as of early 1977, the hospital's Community Mental Health Center became the formal focal point. Prior to AR 600-48, Fort Riley had hired a civilian counselor to work in the center with a primary duty of coordinating the efforts of the SCAN council. But intent notwithstanding, the position developed into that of recording secretary. Only recently, following the formal change in responsibility from public health to social work, have knowledgeable professionals expressed the opinion that the position is expected to rapidly expand to fill the originally intended role of service delivery coordinator. Also for a number of years, Fort Riley, has been conducting training sessions in how to parent; parent effectiveness training; and other progressive group activities into which abusing and neglecting families are integrated.

While their locations are not exactly remote given modern transportation means and standards, to arrive at either post surveyed takes a conscious effort. Fort Hood is a "permanent two division post" which means a political commitment has been made by the defense hierarchy to maintain a large concentration of troops there; the standard number frequently tossed about by Fort Hood professionals is 49,000. The military community then

comprises 49,000 military personnel while the total military community population approaches 135,000. Fort Riley, on the other hand, professes to total military community population of 52,000 of which 19,000 are in the military. This installation is also permanent and the home of a single Army division.

Because both installations have a mission of training and preparation for combat, the majority of military personnel on each post are combat troops. Relatedly characteristic of combat troop oriented installations are frequent sponsor absences from the home. Extra duty, beyond normal duty hours, may range from a few hours on some work project to overnight guard duty; numerous extended absences are also characteristic and may range from three days to six weeks or more for field training exercise.⁷ With this combat troop orientation--as opposed to a technical specialty orientation of a small installation or a school--comes a military community population bottom heavy with low rank and youth; relatively new marriages; young children; and a high turnover rate which translates into frequent moves. These factors correlate highly with available military community child abuse and neglect statistics compiled during 1975 in a similar setting at Fort Lewis, Washington, by personnel at the Madigan Army Medical Center.⁸

Professionals at both installations voiced much

sincere concern over the present state of child abuse and neglect both in general and over different local aspects of case management. Vivid examples of classic and bizzare child abuse and neglect incidents occurring both prior to and after the ACAP were cited by professionals to underscore these concerns. Both installations had recently sent military and civilian professionals to national and regional meetings and conferences on the topic.

Each installation possesses a nearly identical set of resources--or potential resources--available to the military community. See Appendix B. One additional Fort Riley resource exists in the manner the divisional (troop level as opposed to installation level) psychological and social worker resources are concentrated in a separate organization called the Command Consultation Group.

A major distinction between Fort Hood and Fort Riley exists in the conceptualization; availability; employment; influence; and effort of local civilian child protection service agencies. The Kansas Social and Rehabilitation Services (SRS) handle only cases with residence off the military installation with "jurisdictional" problems cited for justification. SRS professionals generally feel they lack the resources as well as the authority to work on federal property. Nevertheless SRS representatives from both contiguous counties regularly attend SCAN council meetings, but no one considers them more than

invited guests.

Texas Department of Public Welfare (DPW) personnel charged with child protection likewise participate in Fort Hood CPC activities. However, unlike Kansas, the Texas DPW case workers are not hampered by jurisdictional dictates and in fact are aided by a mutual agreement. The Fort Hood commander has, in effect, provided DPW a standing invitation to investigate child abuse and neglect reports on the federal installation to include home, parental, and child conditions and otherwise operate as the agency is designed, and DPW has agreed to operate on the federal property.⁹ Backed by local (district) courts, the DPW effects removal of the child when necessary. Military resources are utilized for subsequent care and treatment wherever possible. For example, military families residing on the installation are certified by the state as foster care agencies and the Army hospital commander will treat/admit an otherwise eligible dependent pursuant to a request by DPW case workers supported by district court order; in such a case the child would not be released to parents, but to DPW professionals.

The State of Texas initiated a major campaign to encourage awareness and reporting a child abuse and neglect in 1974. Fort Hood wholeheartedly participated in that campaign, and the effects of it remain visible throughout the installation. The Fort Hood "hotline" for making

reports is 685-5437, which necessitates an on-post reporter dialing 5-KIDS. Duty hours calls are answered by the hospital's Social Work Services while after duty hours reports are taken by a chaplain's assistant who makes appropriate referrals; the number is continuously manned.

Also, potentially impacting on child abuse and neglect case management at Fort Hood is a newly approved Behavioral Services Branch within the established law enforcement program.¹⁰ This branch will consist of both military police investigators and social work technologists who will have the mission

to investigate, refer, followup and treat individuals involved in behavioral incidents who are members of the military community, whether residing on or off [the] Fort Hood Military Reservation [Behavioral Services Branch, 1977, p. 1].

Originally envisioned to assist in the handling and processing of delinquent juveniles, some Fort Hood professionals envision a major role in all types of crisis situations including child abuse and neglect incidents.

Sample Criteria and Description

Although each Army installation had given permission for the survey to be conducted, individual participation was strictly voluntary. Specific criteria for inclusion at both Fort Hood and Fort Riley consisted merely of being a professional as previously defined. Each resource agency or activity was personally visited by the writer

and an on-the-spot determination made about which persons would be considered professionals and offered questionnaires. Position was given precedence over rank; decision-making over mere contact. This criteria resulted in identification of 230 professionals at Fort Hood and 170 at Fort Riley. Consequently a total of 230 questionnaires were distributed to professionals throughout the Fort Hood military community and 170 throughout Fort Riley. Return rates resulted in 29.13 percent (67 questionnaires) representing Fort Hood and 34.12 percent (58 questionnaires) representing Fort Riley. A copy of the survey questionnaire is at Appendix C.

It is evident that the military community places some degree of value in experience and education when dealing with child abuse and neglect case management. Even in populations laden with youth, like the surveyed communities, the average respondent age is 35. Each possesses an average of nine years experience in his or her particular discipline and an average of eight years working association with a military community. There is a general tendency to permit a low experience level in those disciplines requiring the most civilian medical education such as pediatricians, some nurses, and mental health personnel. Those disciplines not necessarily requiring extensive civilian education appear to be compensated for in the area of child abuse and neglect case management with higher experience

levels; examples include: general staff officers, Red Cross workers; and law enforcement personnel. One notable exception is the low experience level of community (local, civilian) child protection service agencies; although a moderate amount of civilian education may be required, both public service agencies represented in Texas and Kansas have experienced notoriously high personnel turnover rates.¹¹

Of the 125 respondents, 71.5 have had some personal experience with a child abuse and neglect case management situation in a military community. Notwithstanding the fact that over twenty-eight percent of the respondents have had no experience factor on which to base their opinions, each is a professional; each is in a position where the situation could present itself to compel judgment to be rendered and decisions made by the respondent. General sample characteristics are recorded by "Personnel Category"¹² in Table I. (See page 37)

TABLE 1
CHARACTERISTICS OF SURVEY RESPONDENTS

PERSONNEL CATEGORY	HOOD	RILEY	TOTAL	AVERAGE AGE	AVERAGE # OF YEARS IN PROF.	AVERAGE # YRS. ASSOC WITH MILIT COMMUNITY	PERSONAL EXP. WITH CHILD ABUSE & NEGLECT	
							YES	NO
Alcohol & Abuse Cnslr.	2	1	3	37	10	10	2	1
Red Cross Case Worker	7	2	9	44	13	12	5	4
Army Community Service	2	1	3	44	8	8	3	0
Army Health Nurse	4	2	6	28	7	7	5	1
Chaplains	3	8	11	40	14	9	8	3
Child Care Center/Post Nursery Pers.	0	1	1	29	8	1	0	1
Comm. Child Protection Service Agcy.	1	1	2	25	2	2	2	0
Ped. Ward Nurses	4	4	8	30	10	9	6	2
Emergency Room Personnel	4	1	5	30	8	8	3	2
Family Therap.	1	1	2	36	9	9	2	0
General Staff Officer	1	1	2	44	20	20	1	1
Law Enforce- ment	10	5	15	33	11	11	11	4
Mental Health/ Hygiene	4	6	10	33	4	4	9	1
Ped. Clinic Nurses	1	1	2	27	3	2	1	1
Pediatricians	3	2	5	29	4	1	3	2
School Admn.	4	4	8	39	10	6	7	1
School Nurse	1	1	2	42	17	9	2	0
School Teacher	2	10	12	33	11	9	5	7
Social Worker Services Hosp	8	1	9	31	5	5	9	0
SJA	5	5	10	32	7	7	6	4
TOTALS	67	58	125	35	9	8	90	35

CHAPTER IV

RESULTS OF THE SURVEY

The results of the survey instrument (Appendix C) are grouped into five categories for presentation in this section of the study:

A general awareness category explores the respondent's alertness to the problem and attentiveness toward seeking a solution. Included are various respondents' perceptions of the current system. (Related instrument items include numbers 2, 3, 15, 16, 24, 26, 35.)

Various aspects of the second category, mutuality of knowledge, are explored including both disciplinary education and military training as well as updating personal knowledge through contemporary reading. (Item numbers 4, 14, 20, 22, 23, 24, 26.)

Sequence of contact, the third category, is described from the point of view of those respondents seeking assistance. (Item number 5.)

The spirit of interdisciplinary cooperation is examined in the fourth section on teamwork. Included are respondents' feelings dealing with the mutuality of trust, respect, and confidence as they affect interdisciplinary cooperation. Self confidence is also introduced. (Item numbers 4, 5, 6, 8, 10, 11, 12, 13, 17, 18, 19, 20, 21, 25, 27.)

The presentation of grass roots ideas formulated by the respondents is the fifth and final category. (Item numbers 7, 35, 36.)

No particular distinction has been drawn between a first or second choice response to most questions. The opportunity was provided for selection of each respondent's own personnel category while simultaneously permitting him to cross disciplinary boundaries. Interdisciplinary relationships may be more accurately recorded and more thoroughly examined utilizing two choices. An exception is made when examining responses relating to sequence of contact.

Category One: Awareness

There is no evidence to suggest any professional surveyed was totally uncognizant of either the existence of child abuse and neglect in the military community or the fact that the military is attempting to deal with the problem. However, there is abundant evidence which indicates many professionals are not fully aware of the Army Child Advocacy Program by that name. Nor are they aware of the basic ACAP details, such as the respective functions of the ACAP council and the CPCMT. In some instances, there is a lack of awareness even of the local operationalization of AR 600-48, to include ACAP council and CPCMT membership, point of contact for case reporting, and on-going inter-agency interdisciplinary cooperation

measures. This is true in spite of the fact that 73.6 percent of the respondents have personally experienced some form of child abuse and neglect case management situation in a military community. The remaining 26.4 percent without such experience do not comprise the entire category of professionals demonstrating a lack of procedural knowledge. In fact, some professionals possessing a thorough knowledge of the program lacked an experience factor in their present duty assignment.

Thirty-two percent of the total respondents as well as 32 percent of respondents with experience believe the Army currently has a highly effective procedure for dealing with the problem. Of those respondents with experience, 42.4 percent believe the current Army procedures are not highly effective and 25.6 percent are undecided.

Although only 84 percent of the 125 respondents believe the Army should be concerned with a professional team approach to child abuse and neglect case management, virtually all respondents are aware of some Army effort in the area. However, the perceptions of those efforts vary widely. Differences are apparent between the ACAP and perceived reality and between perceived reality and what is thought to be desirable. For example, paragraph 11 of AR 600-48 provides for the mandatory inclusion of pediatricians, psychiatrists, psychologists, social workers,

nurses, and lawyers on the CPCMT; yet some respondents would routinely exclude each or all of these personnel categories from the case management decision making process.

When asked whether or not each was satisfied with the role of his own personnel category in child abuse and neglect case management, 84.8 percent replied he was with 13.6 percent expressing dissatisfaction. Those who were not satisfied with their part were very liberal with suggestions for role alteration.

The community child protection service agency is thought to have the greatest influence in the existing decision making process. The multidisciplinary CPCMT is seen as taking a back seat to the desires of the civilian, state agency. Social workers and pediatricians, in that order, are seen as the next most influential disciplines. When the aspirations of the respondents are examined, there is definite desire to decrease the perceived power of the civilian child protection agency as well as that of the local family courts. To accompany these civilian institutions would be two military personnel categories--those of law enforcement personnel and the Army health nurse. A corresponding increase in influence would be granted the mental health professionals; family therapists; and the Army hospital commander. The greatest overall increase in decision making power would be granted to the

CPCMT as a whole.

Notwithstanding the spirit and letter of AR 600-48, the CPCMT is viewed as the child abuse and neglect case manager 15.8 percent of the time. Even if the respondent's aspirations for the CPCMT were granted, the body would still control less than a quarter of the time. When the element of military rank is pitted against the element of knowledge, just over half of the surveyed professionals feel knowledge is controlling. One quarter of the respondents avoided making the choice, and the remaining quarter definitely believe rank dominates the case management decision-making process at the expense of subject knowledge.

The replies of the respondents coupled with the interviews conducted and the general reception accorded the writer and the project evidence a genuine concern about the topic by professionals in the military community. Nevertheless, 72 percent of the respondents remain unread on the subject in the last year.

Sixteen percent of the professionals failed to identify anything they believed to be a goal of child abuse and neglect case management; this minority category was nearly equally divided between respondents who merely left the question unanswered and those who stated they did not know any specific goals.

The remaining 84 percent correctly mentioned one

or more of the functions listed in paragraph 11c of AR 600-48 as the CPCMT Goal. Most commonly listed were the identification of cases; treatment of the child, parent(s), or family; protection of the child; and the coordination of resources function. Generally ignoring the CPCMT function of making recommendations to the ACAP council in either specific cases or on general policy matters, many respondents ascribed to the CPCMT certain functions specifically reserved by the regulation for the ACAP Council. Most frequently appearing were items relating to reporting networks and preventive measures such as community education, parent education, and publicity.

Category Two: Mutuality of Knowledge

As previously noted, nearly every academician, administrator, or practitioner who has written on the subject of child abuse and neglect has drawn some conclusion or made some inference about the necessity for a multidisciplinary approach to problem solving in general and case management in particular. An overwhelming number of military community professionals concur. Only eight percent of the respondents thought the Army should not be concerned with a multidisciplinary concept in its case management approach. Another eight percent were non-committal on the subject. Red Cross case workers and law

enforcement personnel account for eight of the ten negative responses; but when asked which personnel category should assume total responsibility, eight of the sixteen selected responses named multidisciplinary agencies such as the CPCMT, hospital commander, and mental health services.

As the case management decision making process currently exists 53.66 percent of the respondents believe knowledge is more influential than military rank or civilian status. The reverse is believed by 22.76 percent with 23.58 percent non-committed. When asked if the respondent felt personally qualified to participate in child abuse and neglect case management decisions, 64.2 percent believe they are; 22 percent believe they are not; and 13.8 percent did not know if they felt personally qualified or not.

The consensus of the respondents points up the belief that the CPCMT is the single personnel category best trained to handle child abuse and neglect case management situations (24.1 percent). When the particular responses of the fifteen CPCMT members are examined, one discovers one-third claim no professional education on the subject and 60 percent have had no military training with 27 percent (2 social work personnel; 1 lawyer; 1 mental health center counselor) responding with a total void of formal learning experiences in the area of child abuse and neglect. Nevertheless fourteen of the fifteen CPCMT members consider themselves personally qualified to participate

in the case management decision making process; one individual was not sure of his personal qualification. The professional experience level of the CPCMT's averages six years as does military community association.

Following the CPCMT, respondents perceive local, civilian community child protection case workers as the best trained personnel (16.4 percent). Military social workers are next with a 15.5 percent selection rate followed by pediatricians (9.5 percent) and mental health personnel (9.0 percent). Four and one-half percent of the choices named the ACAP council.

When these perceptions are compared with actual training reported by the respondents, the perceived ordering of best trained personnel is just that--a perception. One hundred percent of the pediatricians, family therapists, public health nurses and school nurses received professional child abuse and neglect training followed by 70 percent of the mental health case workers, 60 percent of emergency room personnel, 53 percent of law enforcement personnel, 50 percent of the child protection service agency case workers, and 44 percent of social work case workers. These figures compare to total professional education responses of 48.78 percent affirmative and 51.22 percent negative.

Military and civilian participation in in-service training totals 25.8 percent affirmative and 74.2 negative.

Leading with 100 percent are the child protection service agency case workers followed by 75 percent of the public health nurses and 53 percent of the law enforcement personnel. Twenty-two percent of the mental health case workers, 12.5 percent of the social work case workers, and none of the pediatricians reported any military training on the subject.

When only the respondents in a medical discipline are considered, an average of 63.7 percent have had professional training in child abuse and neglect, but only 25.5 percent have been exposed to any military treatment of the subject. This compares to 39.5 percent affirmative responses for professional training and 25.9 percent affirmative responses for military training reported by personnel in non-medical disciplines.

The most often mentioned form of military instruction was "in-service" training, usually seminars conducted by knowledgeable professionals; diverse locations were mentioned for this training such as Madigan Army Medical Center at Fort Lewis, Washington, and Camp Zama, Japan. The two most often mentioned Army schools were the Academy of Health Sciences and the Military Police School. The former was credited with mentioning the subject of child abuse and neglect in both Officer Basic and Advanced Courses; presenting some depth in the social work Advanced Individual Training phase; and an in-depth treatment

spanning 40-60 hours in a Clinical Specialists Course the academy offers. In addition to the Officer Basic and Advanced Course mentionings of the Military Police School various aspects of the subject are taught in the Military Police Investigator's Course and in several criminal investigation courses. Credit was also given to instruction at the Armed Forces Institute of Pathology.

By far, colleges and universities and professional graduate schools are responsible for providing most of the professional training in child abuse and neglect recorded by respondents. The gamut between small and large and relatively obscure and well-known institutions representing every geographical region of the nation were mentioned by name. The only other category of professional education was provided by an amalgamation of state and federal governmental agencies; national, non-profit service or study organizations, and professional societies through a network of seminars, conferences, institutes, meetings, and workshops. Such organizations as the Texas Department of Public Welfare, the Kansas State Health Department, the Office of Child Development of DHEW, the American Humane Society, Parents Anonymous, the American Medical Association as well as several private and public hospitals were also specifically mentioned by name.

Many respondents mentioned some variation of the theme "life is an education" claiming they are con-

tinually being educated by the child abuse and neglect case management situations in which they find themselves.

Some made comments about frequently returning to basic published sources on the subject, and a few claimed to read "anything I can get my hands on." One hundred percent negative replies were recorded by respondents in the following personnel categories when asked if each had read on the subject of child abuse and neglect during the past year (generally taken to mean during 1976): Red Cross case workers, chaplains, emergency room personnel, family therapists, general staff officers and lawyers. Following closely were law enforcement personnel with 93 percent.

At the opposite end of the spectrum with all respondents replying affirmatively and naming works were: Army Community Service personnel, Child Care Center administrators, Child Protection Service Agency case workers, and school nurses.

A variety of texts and/or authors were named, the most frequently appearing name was that of Dr. C. Henry Kempe, professor and chairman, Department of Pediatrics, University of Colorado School of Medicine. His works, together with Dr. Ray E. Helfer, professor in the Department of Human Development at Michigan State University's College of Human Medicine, were the most frequently cited

authors--their 1972 and 1976 publications share the honor. The remainder of cited texts represent a wide variety of authors currently publishing in the field and authors publishing in closely related fields. Professional magazines and journals were frequently named as were DHEW publications and literature published by national, non-profit public service organizations such as the American Humane Society and Parents Anonymous.

Category Three: Sequence of Contact

The personnel categories to which the surveyed professionals indicated they would first turn for advice should the occasion arise are indicated in Table 2. (See page 50.) No single discipline has a monopoly. Nearly one-quarter (24.6) percent of the respondents would seek case management advice from the CPCMT. Another 13.9 percent would turn toward their local community child protection service agency and 11.5 percent would seek assistance from social workers.

The non-exclusive hold of any single discipline or agency on the advice market is furthered when one realizes only 4.1 percent of all surveyed professional indicated they would first seek advice from a professional within their own personnel category.

The array of second choices is equally as dispersed as primary choices. When both sets of choices are combined, the CPCMT alternative drops to 18.7 percent of the total.

1

[illegible]

Category Four: Teamwork

Over ninety-three percent of the professionals surveyed indicate a willingness to cooperate and work with the members of other personnel categories when dealing with child abuse and neglect case management. Eighty-eight percent flatly deny any competition between their personnel category and the others in this subject area. As stated earlier, 84 percent indicate a multidisciplinary effort should be a subject of Army concern; while simultaneously, a somewhat lesser 62.4 percent claim not to be "disturbed" by joint child abuse and neglect case management decisions. Only one-half indicate willingness to work for members of another personnel category. The responses favoring the concept of teamwork, joining forces against a common enemy, progress pejoratively as the accompanying item wording becomes less directly related to "cooperation" per se, as may be seen in Table 3. (See page 52.)

Typical reasons which support a dislike for joint decisions include: unnecessary delay; "majority opinion is often not the most competent opinion;" "some personnel categories fail to understand other personnel categories limitations;" a concerned agency is often completely disregarded; "partial case management results--too many referrals and not enough deciding result from the [CPCMT] meetings."

TABLE 3

TEAMWORK

ITEM	PERCENTAGE OF RESPONSES FAV- ORING TEAMWORK	PERCENTAGE OF RESPONSES NOT FAVORING TEAM- WORK	PERCENTAGE NOT RESPONDING	TOTAL
Cooperation	93.6	0.8	5.6	100.0
Competition	88.0	6.0	6.0	100.0
Multidisciplinary Effort	84.0	8.0	8.0	100.0
Joint Decisions	62.4	24.8	8.8	100.0
Working for Others	50.4	21.6	28.0	100.0

Selected as the single personnel category professionals prefer to work for is the CPCMT with 15 percent , of the named choices. The ACAP council is selected at a five percent rate. Other personnel categories exhibiting leadership in the field are civilian courts and child protection services (12 percent); mental health workers (11 percent); social workers (10 percent); and pediatricians (10 percent).

Supportively, 22.5 percent identified either the ACAP council or the CPCMT as the personnel category that should set the limits of professional involvement for them. The civilian courts and the child protection services followed with 10 percent of the choices and the lawyers were next with 8 percent. It must be noted that 34 professionals (27.2 percent) refused to cross personnel categories and selected their own personnel category to establish the limits of their professional involvement in child abuse and neglect case management.

When choices were examined from a broader base-- that of a general profession--it becomes apparent that professional clannishness as discussed by Moore (1976) throughout his text is a reality. School teachers and administrators chose themselves or each other as supervisors 48.6 percent of the time. Members of the medical profession accounted for 80 choices in the survey; 42 or 52.5 percent of the selection went directly to them--

selves or other medical personnel categories. If the 23.8 percent selection rate for the medically controlled CPCMT's are added, the non-medical professionals are excluded three to one from the role of supervisor over members of the medical profession.

All professionals except seven (5.6 percent) consider their personnel category generally willing to share specialized knowledge in the case management area.

When the opportunity was presented to become selective and routinely exclude specific personnel categories from participating in the decision making process, Forty-eight of the professionals surveyed (38.4 percent) refused to exclude any category. Of the remaining 61.6 percent, seven professionals, (5.6 percent of the total number surveyed) would exclude themselves from decision making on a routine basis.

The personnel category selected by the professionals as least likely to deliver the services it should was unit commander. The unit commander category out-pollled its nearest competitor by over a two-one margin with 14.5 percent of the selections. The CPCMT received 1.7 percent of the selections.

Likewise, unit commanders were selected as the category least qualified to participate in the decision making process, but in this survey the top percentage of 14.7 percent must be shared with the general staff officer

category. A distant third (9.2 percent) was the category of hospital administrators.

Relatively low positions were accorded unit commanders and general staff officers when "confidence in judgment" was examined and when "most valuable to consult" was determined. Top positions in both categories are held by the CPCMT with the civilian protection services following.

The same relative positioning is evidenced by the responses in selecting the personnel category best qualified to have overall responsibility for child abuse and neglect case management. Table 4 represents the complete results. (See page 56.)

Category Five: Grass Roots Ideas

Survey participants who did not respond to an item soliciting suggestions for improving the child abuse and neglect case management program totaled 38.4 percent. Of those who did respond (61.6 percent) it is evident most of their comments deal with complaints about local conditions, personalities and relationships and are not as much suggestions for program improvement as they are for altered program implementation. This is evidenced by the detailing of a number of items as suggestions that are already an integral part of the ACAP as published in 1975. Suggestions were also made to begin certain specific programs or practices locally that had been on-going at

TABLE 4

RESPONDENTS' SELECTIONS AS BEST QUALIFIED FOR
OVERALL CHILD ABUSE AND NEGLECT
CASE MANAGEMENT RESPONSIBILITY

<u>SELECTIONS</u>	<u>PERCENT OF TOTAL CHOICES</u>
CPCMT	25.6
Child Protection Agency	16.6
Social Work Services	13.0
Mental Health Services	10.4
ACAP Council	4.9
Pediatricians	4.9
Health Nurse	4.5
Hospital Commander	4.0
Family Therapist	3.7
Army Community Services	2.7
Civilian Courts	1.8
Law Enforcement	1.8
U.S. Magistrate	1.8
Unit Commander	1.3
Lawyers	.9
Chaplains	.4
Emergency Room Personnel	.4
Hospital Administrators	.4
Pediatric Clinic Nurses	.4
School Nurses	.4

least two years on the same installation at the time the suggestions were offered.

One professional from social worker services recommended the establishment of "a committee whose sole function is to monitor and check child abuse and neglect cases starting from [the first] to last day." Numerous professionals suggested the Army begin "Parent Effectiveness Training" and broaden community education programs. The suggestion was made to follow cases from Army installation to Army installation when the family is transferred; another to start a central file to keep track of cases and collect accurate statistics on the problem. Several professionals made pleas for someone to evaluate and up-grade or increase as necessary various human services ranging from routine medical care to recreation alternatives to the establishment of crisis shelters and foster homes. Better and increased professional training was called for as was better and increased command involvement. All the above ideas are explicitly incorporated into AR 600-48.

Pleas for shifting CPCMT emphasis from its punitive outlook to a rehabilitative outlook and from its rehabilitative outlook to a punitive outlook are recorded from the same installation as are pleas to shift CPCMT emphasis from the medical condition of the child victim to the social conditions of the family and vice versa;

and pleas to shift CPCMT orientations from maintaining the abusing family unit integrity to strictly child protection and vice versa.

Many comments were made, but without corresponding procedural suggestions, to upgrade interprofessional communication, improve coordination, and develop follow-up and feedback procedures. A common lament was the exceptionally slow speed with which tasks are accomplished; even individual professionals who feel the Army has a highly effective and otherwise praiseworthy program expressed concern. Just as many professionals registered concern that far too many people are involved in any given individual case as registered concern that far too few professionals have input in individual cases.

Suggestions that concern the Army-wide application of the ACAP relate to three major areas: program responsibility, child removal, and jurisdictional issues. Control over military dependents was repeatedly called for by professionals in eleven different personnel categories; their collective plea may best be summarized in the word of one seasoned law enforcement professional, "I'll never be satisfied until military jurisdiction is reestablished over camp followers."

An effective means for rapid, temporary removal, especially in cases not requiring hospitalization, is another request by professionals involved in the direct

and pleas to shift CPCMT orientations from maintaining the abusing family unit integrity to strictly child protection and vice versa.

Many comments were made, but without corresponding procedural suggestions, to upgrade interprofessional communication, improve coordination, and develop follow-up and feedback procedures. A common lament was the exceptionally slow speed with which tasks are accomplished; even individual professionals who feel the Army has a highly effective and otherwise praiseworthy program expressed concern. Just as many professionals registered concern that far too many people are involved in any given individual case as registered concern that far too few professionals have input in individual cases.

Suggestions that concern the Army-wide application of the ACAP relate to three major areas: program responsibility, child removal, and jurisdictional issues. Control over military dependents was repeatedly called for by professionals in eleven different personnel categories; their collective plea may best be summarized in the word of one seasoned law enforcement professional, "I'll never be satisfied until military jurisdiction is reestablished over camp followers."

An effective means for rapid, temporary removal, especially in cases not requiring hospitalization, is another request by professionals involved in the direct

delivery of services. In many respects this perceived problem is closely related to the general jurisdictional apprehension under which the professionals operate.

Only two ideas from all the comments collected represent novel approaches to the way the military has been and is currently handling the entire problem of child abuse and neglect. The first idea is from a young, American Red Cross case worker, and as he readily recognizes, is far from practical.

Bar from reenlistment married personnel under the age of 25, and give a \$500.00 per year bonus to every soldier that remains unmarried until age 25.

The case worker continues:

This may sound like a rather far out suggestion however, the military places servicemen and their families (young wives and tots) under severe stress due to separation of family members and living in areas not of their choice, where mature, responsible friends are often difficult to find. The loss of man hours, indebtedness of soldiers, and anxiety on the job due to marital problems, pending divorces, etc., is easily worth \$500.00 a year to the Army. Ask any First Sergeant how many hardship discharge requests and expeditious discharge requests are submitted based on 'family' problems. Often they result because the wife cannot adjust to a military environment and persuades the serviceman to get out of the Army. The serviceman finds he cannot 'fight' the Army all day and his wife all night, so he concedes. God only knows what happens in the meantime--child abuse is probably a big part of it. Any reduction in the number of married couples (and dependent children) would be a positive step in improving 'case management.'

While totally out of the question for serious consideration by Army policy makers, the suggestion is included by the writer because it very pointedly demonstrates in practical language that much of the Army approach to the problem may be missing the mark perhaps because the wrong ammunition is being used.

Notice the case worker, despite his employment in the social sciences, never once mentioned any sort of humanitarian concern as fills AR 600-48. He talks about dollars and common sense; efficiency; lost time; in a word, economy. Noteworthy too, is "Ask any First Sergeant . . .," rather than company commander. The unit commander is young, relatively inexperienced, and although they may take a different form, is often faced with as many conflicting priorities as the young enlisted man. The Red Cross case worker also hit upon several child abuse and neglect situation contributors--partial causes--including family separation; unwanted mobility; lack of responsible friends; financial problems; and fighting the Army. Miller (1976) touches on most of the same factors in his "typical examples."

One of the community health nurses interviewed briefly outlined a program borrowed from a civilian community organization near another Army installation, Fort Sill, Oklahoma. The program consists of a volunteer force of good "neighbors" which will provide the "responsible

friendship" so often found lacking by Miller (1976), the Red Cross case worker cited above, and many other professional practitioners. The volunteer program, actually borrowed from the Child Abuse Council of Comanche County, Lawton, Oklahoma, has a simple set of ground rules: the volunteers must all be successful mothers; each must be capable of becoming a loving friend; and must have resources (time, transportation, desire, etc.) to develop a "relationship"--defined as a "personal balance"--with an abusing mother or a mother in a high risk category. The friend in effect, becomes a link between the client and professional help. The lay therapist focuses on the mother, not the child--although she reports any concerns she has for the child's welfare. Such a mother to mother professional pairing in Comanche County is designed as a long term, three to four year project. Only one case is assigned to a volunteer, and the volunteers are free to call their social work coordinator for advice at any time: volunteer group meetings are conducted at least monthly to discuss mutual problems, share solutions, and expose new volunteers to the types of situations they may encounter. Emphasis is on the development of a personal relationship--not the formal therapy the client may or may not be engaged in.¹³

The community health nurse is seeking to attempt both primary prevention by identifying high risk clients

and secondary prevention by targeting known abusing mothers. It is interesting to note when she approached a particularly well known group of volunteers already organized and working on most Army installations, she was turned down primarily because association of the group with child abuse would not be good for its image. Another group was approached, refused, and later reconsidered and accepted the challenge.

CHAPTER V

INTERPRETATIONS, IMPLICATIONS AND RECOMMENDATIONS

The object of the following comments is improved child abuse and neglect case management for the military community. It is virtually not possible to divorce case management from the greater Army Child Advocacy Program. While some of the following twenty-two subject areas appear at first glance to only be tangentially related to the subject at hand, all are germane to the issue.

The comments contained herein are strictly those of the writer based on personal experience, research, and subjective evaluation of alternatives. An effort to keep all recommendations practical has been made; some are obviously more practical than others. Certain topic headings are followed by a mere statement of an identified problem without specific recommendations; an effort was made to keep these at a minimum. The sequence is not related to importance nor to any scheme of priority; it is merely alphabetical by subject area.

Army Child Advocacy Program (ACAP) Council

Establish an ACAP Council as currently provided for in AR 600-48--one that is relatively high powered, has influence with the command group, and will be concerned with major policy decisions and trends. If the regulation

suggestion to permit the existing Human Resources Council, to assume the ACAP duties is followed, at least until the ACAP gets off the ground, a subordinate working group (meeting considerably more frequently than the standard quarterly HRC) should be formed. This sort of sub-committee should include company and battalion level commanders and become involved doing precisely what AR 600-48 outlines as the functions of the installation ACAP council. It will be a type of steering committee to direct local research efforts, analyze the problem, and make policy recommendations to the formal ACAP council. An important key is to involve the command--against command wishes, if necessary.

The steering committee must be separate from the CPCMT and not concerned with individual case management. It should, however, like the CPCMT, become an action agency, working toward coordinating installation-wide activities and efforts (such as a publicity campaign) and on-going, separate programs all the while striving for improved military community conditions for children. Paragraph 4c of AR 600-48 states:

Although military installations and surrounding civilian communities usually offer a wide range of services for children, families and children often are unable to obtain necessary support from these agencies and institutions.

It is the duty of the ACAP council to render that scathing

indictment of the military community superfluous.

Case Management Decision Responsibility

The concept of employing a single agency as the sole coordinator of military community child abuse and neglect activities is not new; that was the original purpose of the William Beaumont General Hospital's Infant and Child Protection Council and to a large degree remains a purpose of the CPCMT's as they are employed. By calling for the designation of a single agency, the AR 600-48 designation of the Army Hospital commander as CPCMT organizer and supervisor and his further duty to

designate a staff member, usually a social worker or community health nurse, as a point of contact to receive and act upon all reports of child maltreatment referred to the [hospital] [paragraph 8b(2)],

are not being either usurped nor superseded--merely refined.

Specific regulatory guidance is required to insure the staff member selected by the hospital commander is relieved of all non-child abuse and neglect duties; reports directly to the hospital commander; becomes the CPCMT leader, the decision-maker in all CPCMT matters; and is given authority commensurate with responsibilities. If the position were established by regulation, it would result in a vastly improved case management program; fixing responsibility would become possible; better records would be maintained. Accessibility for decision

making would be increased thereby increasing the speed with which actions could be taken. Removal of the "shared responsibility" concept decried by some professionals would result in more determined decisions and activity.

This special assistant to the hospital commander would need to possess leadership ability and management skills. Individual identification of CPCMT leaders is discussed under Personnel Management, but a recommendation that a social work officer be selected is in order. Knowledge, skill, and an acceptance by other professionals are mandatory. Training and experience fairly account for the first two; the acceptance criteria, although more difficult to ascertain, appears relatively satisfied. The single discipline of social work was selected over all other individual disciplines as the one most professionals would choose to work for if the occasion arose. These findings support Lehman's general child maltreatment case management recommendation in 1973 that

although a multi-discipline group will be required for operation of the program, I feel that members of the Social Work Service, Office of the Surgeon General, are the logical individuals within the military staff to perform the function of "organizing" and "administrating" [p. 25].

Lehman goes on to cite his reasons which include coordinating experience, a broad knowledge of hospital affairs, and technical knowledge and proficiency.

Administratively, whichever profession is selected

as CPCMT leader, it will represent a "diagonal shift" in his or her career pattern as Moore (1970) terms it. There exists great non-military as well as military medical precedent for such "supervision of peers" by a former professional, administrator. ("Professional" here being given its common definition.) Hospital commanders are physicians as are hospital Chiefs of Professional Services.

The designation of a single agency to head the CPCMT would serve the added function of relieving pediatricians of the administrative burdens they now bear as the traditional Chairmen or Presidents of CPCMT's as so many of them seem to be. Both their common lament for additional time to fulfill their primary function and the Army's growing problem of a physician shortage would be somewhat eased. This concept coincides completely with the opinions of Thomson, Paget, Bates, Mesch, and Putnam (1971) when they state "physicians should not have to bear ultimate responsibility for program operation [p. 59]" because of scarce resources such as time.

Chaplains. Surprisingly, chaplains appear to be suffering from a low credibility rating in the area of child abuse and neglect case management. This is in spite of the fact AR 600-48 specifically assigns the Chief of Chaplains the responsibility to "... support the ACAP with resources and technical assistance ... [paragraph 6d]." Perhaps

impetus is needed through technical (chaplain) channels to cause local, installation chaplains delivering services to overcome their apparent inertia. Chaplains are professionals, and although they have other more common duties, must be prepared to become involved in case management.

Child Care Centers. Child abuse and neglect case managers make insufficient use of military community child care centers. This may be due in large measure to the financial aspects involved; as one administrator remarked, "My prices out-class a lot of the abusing and neglecting clientele." Although child care centers are usually non-appropriated fund activities (receiving little or no Congressionally appropriated funding), some manner of overcoming the funding problems must be found. Not only should they be available in crisis situations, the child care centers could be routinely employed by case managers to ease household and familial tension and stress. Consideration should be given to child care center use as a medical prescription; the government would have the responsibility to fill that prescription for eligible personnel just as it now dispenses medication from its hospital pharmacies.

Child Protection Case Management Team (CPCMT)

The CPCMT must be a group, separate and distinct from the installation ACAP council. The latter is con-

cerned with policy decisions, the former with individual case management. Policy recommendations would be made by the CPCMT to the ACAP council as needs were identified.

CPCMT composition should consist of on-hands, practitioners--those professionals actually delivering services in the case--not service delivery agency supervisors. The membership of the CPCMT would then vary from case to case; this variation would be evident not only in the different personalities involved, but in the different combinations of disciplines that may be involved as well. Some factors which may be relevant to deciding membership in a given case include: how it was first discovered; who reported it; type of incident; prior family contact with helping agencies; relative urgency of action required; and the like. No personnel category would be routinely excluded, but neither would any be routinely included.

The CPCMT would have a full-time, permanent leader and decision maker; the services of an assistant or coordinator to aid in following up in decision making would also be required. The CPCMT would be an advisory body, presenting evidence upon which the leader may base his decision. The CPCMT would also be in an employee relationship with the leader--carrying out the decisions. A positive indication toward this end is the willingness of professionals to permit the CPCMT to set the limits of their professional involvement in case management situations.

The CPCMT must undergo an image change. It must be the action agency it was designed to be. The perception of a vague, unmanageable or unmanaged, buck-passing referral agency must be replaced by a goal oriented body, highly visible in individual cases, with the ability to pinpoint responsibility in cases of success and failure.

Command Influence. Evidence indicates all levels of command are on the periphery. For the ACAP or any other program to be as effective as possible, command must become involved. An oft-quoted military axiom of General of the Army Omar Bradley is applicable here: "The troops do well that which the commander checks." A certain amount of education must take place; interest must be cultivated; commanders' time and other important resources must be acquired or earned. Command involvement is mandatory, but it must be constructive involvement or it could be detrimental to the overall program. A commander's attitude like "Give me the names, and I'll see it doesn't happen again," may only serve to drive indications of a problem further behind closed doors and have the effect of precluding early identification and assistance.

Communication. An increase in both volume and quality of communication is needed between professional members in the military community. Not only accurate and timely

information concerning active cases must be passed between specific professionals, but good literature and ideas on the problem area in general must be circulated to all professionals. One method of expanding working ideas and concepts is through a specialized newsletter or bulletin to all CPCMT leaders for subsequent distribution to professionals. It could originate with some central source like the Health Services Command special consultant.

Special emphasis must be placed on the need for accurate feedback--with additional emphasis on progress (or the lack of it) to the initial reporting professional. The apparent lack of on-going communication may be at the root of much evidenced distrust and frustration. Vernon (1972) refers to "partial-group awareness" as a condition existing in any group which contributes toward the maintenance of that group's social stratification system. It may well always exist, but so should the challenge to minimize it and its effects.¹⁴

Army regulation 600-48 may not have been distributed widely enough when it was published; it is not now readily available at company and battalion levels on military installations.

Education. The importance of community primary prevention (i.e. education) must be recognized and sufficient tribute accorded it. The military community should

insist on beginning "Parent Effectiveness Training" (PET) units in all junior and senior high schools in the community. Some PET should be presented to young men shortly after they enter active duty, and continued at duty posts. PET briefings could become a part of normal "in-processing" at Army installations and incorporated into such Army Community Service activities as the "Welcome Wagon."

Mandatory training in making minor household repairs is already standard for personnel moving into government-owned housing; PET could be also. High risk targets such as new arrivals in the community should be favored audiences over established groups such as officers' wives clubs.

Professional education should become a never-ending process beginning with Officer Basic (and appropriate Advanced Individual Training) courses and continuing through in-service training while a professional is on the job. The self-confidence level of professionals must be raised, and military training is a logical starting point. A standardized, two to four hour block of instruction should be devised by the Academy of Health Sciences for presentation at other service schools. If not a what-to-do-when-the-situation-arises approach, at least an awareness of the problem would be spread. Problem identification could be included as well as a section on ramifications of the problem for that particular audience be it lawyers, military policemen, or combat arms personnel.

Presentations would be made by officers of the same branches as the audiences and allowances made for including that particular branch's role in the ACAP.

Innovative Demonstrations. The Army should pay particularly close attention to the measured results of the two U.S. DHEW projects on-going at Fort Sam Houston and Fort Campbell. The military professionals involved at each location should be required to present a separate evaluation of the projects upon their termination--a sort of "Operational Report of Lessons Learned." Consideration should also be given to stabilizing the tours of duty of the key military professionals involved at both locations. Although this would amount to introducing an inordinate amount of personality stability that could not be guaranteed for every program, the results may well prove worthwhile insofar as stem-to-stern military evaluations of the innovative demonstration projects are concerned.

Interdisciplinary Relationships. In the area of child abuse and neglect in the military community, interdisciplinary relationships are, at best, confused. There is an observable tendency for professionals of one personnel category to exhibit some frustration toward the members of another personnel category; the same is true for jealousy and distrust as well as confidence and admiration.

While not overwhelming, the tendency of a discipline to protect its own disciplinary turf is also somewhat in evidence. This concept is generally expressed by insiders placing blame elsewhere and by outsiders presenting a case for the uniqueness of their potential disciplinary contribution and thereby lobby for a participating role in the decision making process.

Every discipline that is involved wants to remain involved, and every discipline not involved wants to become involved. An outright "ownership principle" such as that decried by Lourie and Lourie (1971) is not visible. This may be attributable to the fact that almost everyone recognizes the issue as a complex one and is quite content to share responsibility for its management as long as no simple solutions are known to exist. However, because broad sharing experience seems to have been less than satisfactory in the past, each personnel category wants to retain the option of selecting with which other personnel categories he will cooperate.

These negative, non-cooperative aspects would be minimized if the sharing option was eliminated by some form of edict guaranteed to be client oriented. Minimization would also result if the disciplines and the professionals within disciplines changed from case to case. No negative effect patterns would have the opportunity to develop; the routine and semi-routine tasks

as well as attitudes would be replaced by ingenuity and interest--all to the benefit of improved case management and upgraded services.

Addressing the subject of individual case coordination, the Office of Child Development states:

If a multidisciplined approach is to be achieved and coordination is to be successful, certain relationships and roles must be established or defined early in the development of the program [1977, p. 13].

Implied is the concept that some outside or higher force establish the ground rules before the game is played. Ideally this could be accomplished in the situation at hand by a Department of the Army regulation. But child abuse and neglect case management is not a standard game; there is also need for game plans--and as many sets of game plans as there are games. Since no single document could anticipate every eventuality, the next best alternative is to have a standard, relatively permanent, local authority, like the CPCMT leader, establish the plan. It is utter confusion to turn the players loose and give them a free hand to write their own plan while playing. Too much attention and effort is directed toward that and not enough toward winning the game.

Inter-Installation Referrals. Whenever an active case is transferred to another military community, the gaining installation CPCMT leader should receive the referral

from Health Services Command. Following that, the gaining installation should contact the losing installation, for case particulars not included in the referral notice. Such a notification system will preclude friend calling friend or stranger calling stranger and eliminate the need for crossed fingers that something will be done by the gaining installation. If no contact is made with the losing installation or if Health Services Command fails to receive updated Case Management Summaries the higher headquarters is in a position to take action. Consideration should also be given to making referrals of cases closed prior to departure of the family from a military community. The gaining military community may desire to include the family in a high risk category until it becomes firmly established in its new location.

When an abusing family severs ties with the military community and relocates "back home" or otherwise in a civilian community, a referral should routinely be made to the gaining local child protection service agency. Just as certain alcohol and drug related case referrals are made to Veterans Administration Centers, so should child abuse and neglect referrals be made. The Army recognizes itself as a contributor to the problem, and its responsibility as a contributor to the solution is not completed until it has done all that is possible in acting as an advocate for the military dependent child.

Investigative Agency. The proper agency to initially investigate reports of child abuse and neglect should be determined by the CPCMT leader. That decision would take into account all information known about the incident or report, the availability of various investigative agencies to respond, and the exigency of the situation. Conscious effort should be made by the agency selected to secure complete and accurate data. Because the agency selected was determined best for the job at a particular point in time does not preclude other agencies needing investigative data at a later point. Conscious effort should also be made to preclude a series of investigators, each representing a different agency, descending on the target family simultaneously or in rapid succession. Such is now often the case. While each agency gets sufficient data to complete its own report, the family is often bewildered and more in a turmoil after intervention than before. In short, initial investigations must be well coordinated and well matched to the situation.

Because a variety of situations will call for a variety of initial investigators, sharing data becomes extremely important. Blatant professional jealousy as now exists between military law enforcement personnel and civilian community child protection service agencies must be overcome. The work will be shared; the data must be shared.

Legal and Jurisdictional Issues. Although the writer avowed at the outset not to undertake an examination of any legal or jurisdictional issues, so many professionals are concerned about those issues, a comment is warranted. There is no realistic possibility for the development of a Federal Family or Juvenile Code with which military authorities could exert any manner of legal jurisdiction over dependents.¹⁵ The best hope for any standard rule applicable to the military community would be to lobby for the enactment into law of some legislation that would require each military installation to incorporate the family and juvenile code provisions (at least those portions pertaining to child abuse and neglect) of the state in which it is located. Such legislation could be looked upon as a logical expansion of the federal Assimilative Crimes Statute. Such factors as specific law varying from state to state and U.S. Attorneys being unwilling to prosecute and U.S. District Courts being unwilling to hear cases will be the rule as it is now for many crimes. Just as the military policeman may "legally" intervene in a simple assault situation, so would the professionals be able to "legally" intervene in their area of responsibility. Such legislation might also remove some of the philosophical differences between the military professional and the community child protection service agency. Operational problems would no doubt, continue to

exist, and new ones would be created; but simultaneously, a commonly perceived burden or obstacle would be eliminated, enabling those professionals involved to operate "within the law." Service delivery would increase, if not improve and increase.

Short of federal legislation, pressure for military-civilian working agreements on the Fort Hood model is a viable alternative. While some military disciplinary toes may be stepped on and pride damaged (primarily law enforcement) the result would be superior to constantly being at loggerheads. The agreement, however, should be uniform throughout the state. The agreement should be negotiated at state level and should encompass all Army (if not all military) installations within that state. Precedents could be cited which currently are in operation without any formal agreements: state documents are issued relating to actions taking place entirely on military installations in the case of births, deaths, marriages, divorces, motor vehicle registrations, as well as in adoption proceedings. Additionally, state welfare agencies administer the Federal Food Stamp Program to recipients living on installations. Data concerning state income taxes is also reported to states by the military. Military authorities are now complying with certain state requirements relating to venereal disease, rabies, and other communicable diseases as well as child abuse and neglect

case reporting. An expansion of these into a formal, workable agreement should not be an insurmountable problem.

Personnel Management. Department of the Army consideration should be given to awarding qualified, trained, and experienced professionals a military occupational specialty code designator just as is presently done for military policemen who are qualified traffic accident investigators or for anyone who is instructor qualified. With such a designator, personnel assets could be controlled to maintain an even distribution throughout the Army. Specific qualifying factors could be determined by Health Services Command; ideally an individual would volunteer for the duty.

A policy should be developed that would permit the local CPCMT to either void or delay reassignment orders intended for the military member of a case under active management. This stabilization effort should be considered the equivalent of a medical prescription designed to reduce family turmoil until a determination has been made it has the necessary coping skills. Likewise, the CPCMT should provide justification for reassignment to a specific area if that is deemed wise.

Program Attention. In spite of the fact Army efforts in the child abuse and neglect area during the past two years have been greater than at any other time since realization of the problem, much more attention to

the subject is warranted. The subject should appear on the agenda for commanders' conferences at both the Major Command level and the Major Subordinate Command level. Additional emphasis could be provided by making the implementation of AR 600-48 a subject of special interest by the Department of the Army Inspector General. When Army installations receive their Annual General Inspection from their parent Major Command headquarters, the ACAP Council and CPCMT working should be examined. Additionally, inquiry should be made of non-professionals on each installation concerning the Army Child Advocacy Program as a whole.

The Army Health Services Command should establish a position of special consultant to concentrate solely on the ACAP and provide a technical medical channel impetus to parallel that of command and the Inspector General.

Publicity. There is a definite identified need for intensified efforts in the area of publicity. Not only is the general military community insufficiently aware of child abuse and neglect and what may be done about it, the professional community is not aware of all the current efforts--some of which are long standing. There are many areas within the greater ACAP that warrant publicity in addition to the existence of the ACAP itself. On-going local programs especially in the primary prevention vein, child abuse and neglect warning signs, sources

of help, where and how to report incidents could each be the subject of separate, but coordinated campaigns. Information must be accurate. Maximum tie-in with any state or regional publicity campaigns should be sought.

The major target of any publicity campaign should be the potential client. The abusing or neglecting parent (who may be made aware of his actions and their consequences) and, because of that newly created awareness, volunteers for assistance, should be cultivated. While the anonymous reporting neighbor cannot be totally ignored, the former category must remain the primary focus. Since pressures on the job seem to figure heavily in the military analysis of the problem, the media attack should reach all the way down to the dining facility kitchens and the company supply rooms. As one nurse suggested, "Hang a sign in the motor pool that tells a guy not to go home and take it out on his kids." Provide the suggestion for an alternative while he is still at work.

Removal and Placement. The process of child removal or the absolute lack of a process arouses more professional comments laden with frustration than any other single issue relating to child abuse and neglect in the military community. While there are no doubt cases in which immediate removal would have been the logical alternative and perhaps even have saved lives, the issue of removal looms larger than its cumulative non-use in any

given set of cases. The power of removal is an extremely divisive subject between the military and civilian professional members in the military community. Following the reasoning of Moore (1970) the authority to employ removal knowledge and techniques may well be looked upon as the single most influential factor in military community professionals according such a generally high effectiveness and prestige level to civilian child protection service agency case workers.

The removal and placement of children, more than any other area, appears to be inextricably bound to the area of law; although this is a perception rather than an empirical certainty. The military principle of "hands-off" child removal may be akin to the military policeman's thoroughly ingrained principle of posse comitatus, despite the fact there is no record of any prosecution for violations since the law was established (Murphy, 1975). Notwithstanding legal constraints, emergency removal of a child from an on-post residence should be authorized by competent military professionals--even if the only placement is in the Army medical treatment facility. The real question appears to be just how much of a child's advocate does the Army want to become. A complete set of placement services must become available to military community professionals--crisis nursery; medical facility; day care center; as well as both short term and relatively long term foster

home service. Removal and placement must be looked upon more like medication than a social judgment. The object of this emergency first aid is the health and welfare of the child.

Reporting Child Abuse and Neglect. Within each military community there should be a single point of contact for reporting all incidents and suspected incidents of child abuse and neglect. A widely publicized, easily recognizable and recalled number should be available much like the Fort Hood model, 5-KIDS. The logical choice for the recipient of the reports is the CPCMT leader.

The decision whether or not to report confirmed cases of child abuse and neglect to civilian authorities should not be left to the discretion of the CPCMT as it now is. The regulation should require such action since the civilian authorities are also a part of the greater military community.

Concurring with Granger (1976) the writer believes the subject of good faith reporters being immune from civil and criminal liability should be incorporated into Army policy if not federal legislation.

Research.

The military community offers the researcher far better limits of otherwise uncontrolled variables than that found in most civilian settings. We have a known number of cases coming from a known population and being seen

in primarily one health care system by a single staff.

[Miller, in a 1972 newspaper article, quoted in Lehman, 1973, p. 13].

The research territory is fertile. The Privacy Act is no bar. The need certainly exists.

Army Regulation 621-1, Education: Training of Military Personnel at Civilian Institutions, 6 May 1974, requires nothing more than submission of a single copy of a completed thesis or dissertation to the Department of the Army. No guidance is provided relative to the topic researched. The Department of the Army does indicate the discipline in which the military student will study, and a generally valid assumption is made the thesis or dissertation will be related. But there is no guarantee nor requirement the Army financed research project have any relevancy whatsoever to Army needs. A change is in order. Candidates for advanced degrees, at least those attending under fully funded programs, should be required to secure Department of the Army approval for their research topic. Individuals could be directed to conduct research in a particular area of need or perhaps given a choice of several relevant topics. The subject area of child abuse and neglect is merely one area that could be affected by the results of directed research.

Schools. The CPCMT leader should give every consi-

deration to employing school personnel when school age children are involved in a case. The school teacher is with the child approximately 35 hours per week; properly managed that could be an invaluable asset. The desire to assist is quite in evidence, but before the potential asset may be converted to a real asset, the role of the schools in the ACAP must be understood by both the school system and the ACAP council. From that point CPCMT procedural matters could be developed. Communication-- notably feedback--may be especially helpful in cultivating and maintaining the school system employees as useful program participants.

The schools in the military community must be looked upon as a primary preventive measure. In order to get appropriate materials introduced into the classrooms, the ACAP council should utilize the occupant of a long-established and relatively dormant position, that of Schools Liaison Officer. Be he a civil servant, lieutenant colonel, or command sergeant major, urge the Schools Liaison Officer to participate in a positive action in lieu of just monitoring local school board meetings to make sure the military is not being discriminated against in any way.

Unit Commanders. The very real (lack of) confidence problem experienced by unit commanders in the area of child abuse and neglect must be overcome. During the

Vietnam era, it was not uncommon to see second lieutenants as company commanders; now, that is a rarity. The experience and maturity factors are slowly improving. But also gaining is another standard aspect of a peace-time service--increased attention devoted to one's own job protection and career enhancement and advancement. Officers in general, and in command positions in particular, often appear to be too self-centered and self-serving in their attitudes and actions. These are traits quickly noticed by child abuse and neglect professionals with the consequence that the unit commander is effectively eliminated from any CPCMT contact.

Judging from interviews with professionals as well as their survey responses, the effect of denying specialized knowledge to this category at once provides an observable degree of social stratification as Vernon (1972) suggests, and is lamented. The professionals would genuinely like to include the unit commander in case management; his key position to observe and influence important variables is realized. But the professionals' apprehension that educational efforts will fall on intentionally deaf ears and the general situation will be aggravated, at the present time, are controlling.

The hard work of unit commanders must be redirected through simultaneous pressure applied from below (publicity), from above (command), and laterally (communication

AD-A055 173

SAM HOUSTON STATE UNIV HUNTSVILLE TEX INST OF CONTEM--ETC F/G 5/11
AN EXAMINATION OF SOME INTER-DISCIPLINARY RELATIONSHIPS BETWEEN--ETC(U)
MAY 77 J T MARTIN

UNCLASSIFIED

2 OF 2

AD
A055173



NL



END
DATE
FILMED
7-78

DDC

and education). The key to change is education, but this represents a classic situation where a little knowledge is a dangerous thing. Constructive involvement is a possibility and certainly preferable to remaining in the dark, but even that is preferable to detrimental interference.

Workshop Participation. Professional participants in regional and national conferences, institutes, meetings, and workshops should continue; however, the traditional fare of military tactics should be changed. When involved in a seminar or discussion concerning the military community, it is recommended the military representatives go in with a concrete proposal concerning a particular common aspect of the child abuse and neglect subject area. The "Big Picture" the Army is so famous for would be abandoned. The result of stressing common ground rather than the unique aspects of the military community may serve to permit constructive discussion and inhibit inappropriate and useless rhetoric.

After action reports from all such gatherings should be prepared by the participants and forwarded to Health Services Command who in turn could make distribution of appropriate ideas to the field.

Final Impressions. Teamwork is a concept lending itself to as many varieties of definition among academicians and practitioners as does phrase child abuse and neglect.¹⁶ But most agree the everyday, common sense,

service delivery effect of teamwork is improved case management. Interdisciplinary problems are obstacles to improved case management; and some of the interdisciplinary problems that currently plague the military community in its approach to child abuse and neglect case management have been isolated and examined in this study.

But while most of the study has dealt with numerous negative aspects of military community performance, that does not represent the complete picture. Concern is evident everywhere, the writer sent a letter, placed a phone call, or knocked on a door. Each professional interviewed and/or surveyed evidenced a genuine desire to work toward a solution to the problem. It is the methods each would employ and the manner in which they would be employed that needs the focus of responsible authorities at Department of the Army level.

A major credibility problem exists if the recorded perceptions of the professionals surveyed are not true, but no evidence exists to support that concept. But because they are true, the Army Child Advocacy Program--and especially the Child Protection and Case Management Team Concept--needs a forceful boost.

One may argue that such a confusing array of responses to a set of rather direct questions does not represent a problem of major significance because the ACAP has only been in effect a little over one year.

But consider the fact the CPCMT portion of the ACAP did little else but formally institutionalize a procedure that had been on-going at many Army installations for several years. Why then the confusing array?

The ACAP--not necessarily as conceived and published, but as operationalized (Note that many of the suggested corrective measures contained herein were previously addressed by AR 600-48) is not seen as a concerted program at all, but rather as a group of service agencies, each attempting to "do its own thing." Even the perception of a loose binding by the thread of a common clientele is missing. As one Army lawyer stated, "The operation of the ACAP is more of a reaction to individual or collectively identified incidents and situations than it is any sort of positive action program."

Uniformity of the ACAP administration remains a goal (as does CPCMT functioning); it is not yet reality--and will not become reality without strong, well-directed pushes, pushes at least as strong as the forces behind the initial publication of AR 600-48. A major mobilization--in principle, like that the Army mustered to combat alcohol and other drug abuse, but far cheaper and not as extensive--is both warranted and requisite.

"Child abuse laws provide only the legal and institutional framework for action. A law lives in the way it is used [Besharov, 1975, p. 4]." The same is true for an Army Regulation.

FOOTNOTES

FOOTNOTES

1. Fort Hood statistical interpretations were provided in personal communication with Ms. W. Phillips, March 3, 1977. Ms. Phillips, a civilian professional, is a project coordinator for the Child Abuse and Neglect Demonstration Organization (CAN-DO), a federally funded project through the Central Texas Council of Governments, headquartered in Belton, Texas. CAN-DO has been studying the problems in a seven-county area including the Fort Hood military community for a number of years. Fort Riley statistical information represents the collective opinion of several, knowledgeable military professionals. In neither location were recent, official, comparative, intra-state statistics available to the author.

2. Lieutenant Colonel George C. Welton, ACSW, Ph.D., was Chief of William Beaumont General Hospital Social Work Service when the Infant and Child Protection Council was created.

3. As finally constituted, the Infant and Child Protection Council included the Chiefs of Pediatrics, Psychiatry, and Social Work; Army Health Nurses; a Clinical psychologist; the Army Community Service Officer; and the Regional Director of Child Welfare from the adjoining civilian jurisdiction.

4. Such a conclusion is based on Miller's clinical

statistics for a one year sample, 1971, at William Beaumont General Hospital. A rate of 24.2 cases per 10,000 military families was established with only 10.5 percent of the total cases "severe."

Projected on a nation-wide scale, it would indicate 13,500 families are physically battering and abusing their children. The American Humane Association estimates that there are some 10,000 cases per year of severe abuse throughout the country [Lehman, 1973, p. 15].

Zalba, 1966, estimated up to one quarter million juveniles require protective services annually; De Francis in addressing a National Symposium on Child Abuse held in October, 1971, doubled Zalba's estimate; Gil (1973) has gone higher yet. Projecting Miller's case rate onto the entire Army community, approximately 1,200 child abusing and neglecting families are on Active Duty each year (Lehman, 1973).

5. Quoted in Lehman, 1973, p. 16.

6. Further evidence of the literary and military research void was indirectly provided by the Defense Documentation Center's (DDC) negative response to the author's inquiry in January, 1977. The DDC is a little known activity of the Defense Supply Agency of the U.S. Department of Defense. The activity is responsible for making available from a single, central depository the thousands of research and development reports produced each year by U.S. military organizations and their contractors. The DDC also operates computer-based data banks of management

and technical information concerning current (on-going) research and development projects. To draw a negative reply from such a comprehensive source is significant.

7. See Miller in Helfer and Kempe (1976), pp. 275-282, and his borrowed conclusion, pp. 290-291. See also McKain (1973), especially pp. 6-7.

8. Statistics obtained from the Army Health Services Command indicate a pattern of child abuse and neglect as follows:

<u>CATEGORY</u>	<u>PERCENT OF CATEGORY TOTAL</u>
Age of child under 1 year	31.5
Age of child under 2 years	44.5
Age of child under 3 years	58.0
Age of mother under 21	42.5
Age of mother under 24	54.6
Age of father under 23	46.0
Age of father under 26	70.3
Length of Marriage under 1 year	19.4
Length of Marriage under 2 years	53.4
Length of Marriage under 3 years	65.0
Rank of Sponsor private first class or under	29.2
Rank of Sponsor Specialist Fourth Class or under	49.9
Rank of Sponsor Sergeant or under	75.8

Length of Residence in Military Community under six months	23.0
Length of Residence in Military Community under nine months	35.0
Length of Residence in Military Community under one year	40.0
Length of Residence in Military Community under two years	82.0

9. Several Fort Hood professionals referred to this agreement, each insisting it has been reduced to writing; however, no one claimed to have actually seen the document nor could anyone produce a copy for the author's examination.

10. The Commander of Fort Hood initially approved the concept of the Behavioral Service Section on February 18, 1977. Planning and staffing is presently on-going; the section is scheduled to begin operations during Spring, 1977.

11. This fact and certain child abuse and neglect case management problems created by it were raised by several professionals within each military community surveyed.

12. "Personnel Category" is a term created by the writer to offer a measure of intra-disciplinary discrimination for place, activity, or agency of employment while simultaneously avoiding conflict with existing military terminology.

13. See "Child Abuse Training Series," VTM Unit I: Lay Therapy (Parent Aide), a 25 minute videotape of a volun-

teers' meeting, for a complete outline of the program and a brief evaluation of its effectiveness.

14. For an interesting discussion of "partial-group awareness" and other topics relating to the sociology of ignorance, see Vernon (1972), pp. 179-188.

15. An opposing opinion has been expressed by Miller, December 2, 1974, in a letter to Allen, a portion of which she published in 1975.

"In my judgment the solution is relatively simple. If the Uniformed Services represent a 51st state let the "state legislature" (Congress) enact a 51st state law with policy, staff, and funding commensurate with the other 50 states. The other alternative is to turn the matter over to the 50 states and pay them to do the job on military bases. I think this latter course would not be desirable because the states and affected families need military assistance with these programs. The military community also needs to understand its system will never be done if such problems become solely the responsibility of the civilian community." (. 20)

16. See National Center on Child Abuse and Neglect (1976), Volume 3, page 2, for a definitional discussion of the teamwork concept.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Allen, Marilyn. "Child Maltreatment in Military Communities." Juvenile Justice, May, 1975, pp. 11-20.
- Arellano, Benito M. "Systems of Handling Child Abuse/Neglect, Child Protective Services: A Survey of Selected CONUS Installations." Unpublished report, Fort Leonard Wood, Missouri, 1970.
- Behavioral Services Section draft proposal Fort Hood, Texas, February, 1977. (Typewritten)
- Besharov, Douglas J. "Building A Community Response to Child Abuse and Maltreatment." Children Today, September-October, 1975, pp. 2-4.
- Caffey, John. "Multiple Fractures in the Long Bones of Infants Suffering From Chronic Subdural Hematoma." American Journal of Roentgenology, LVI (August, 1946), 163-173.
- Cheney, Kimberly B. "Safeguarding Legal Rights in Providing Protective Services." Children, May-June, 1966, pp. 86-92.
- Cherry, Barbara J., and Kuby, Alma M. "Obstacles to the Delivery of Medical Care to Children of Neglecting Parents." American Journal of Public Health, LXI (March, 1971), 568-73.
- Child Abuse Council of Comanche County (Oklahoma). "Child Abuse Training Series." (Videotape). VTM Unit 1: Lay Therapy (Parent Aide), 25 minutes, undated.
- del Valle, Alline, and Alexander, Felton. "Effects of the Project (ENABLE) on Family Service Agencies and Urban Leagues." Social Casework, XLVIII (December, 1967), 633-8.
- Delsordo, James D. "Protective Casework for Abused Children." Children, November-December, 1963, pp. 213-18.
- Department of Health, Education, and Welfare. Report of the U.S. Department of Health, Education, and Welfare to the President and Congress of the United States on the Implementation of Public Law 93-247, the Child Abuse Prevention and Treatment Act. Washington: Department of Health, Education and Welfare, 1975.

Department of the Army. Army Regulation No. 600-30, Human Self Development Program. Washington: October 19, 1971.

Department of the Army. Army Regulation No. 621-1, Training of Military Personnel at Civilian Institutions. Washington: May 6, 1974.

Doeltz, Deloris, and Adamson, Duane. "The Collaboration of Chaplain and Social Worker in Hospital Care." Social Casework, XLIX (July, 1968), 410-13.

Eisenberg, Leon. "The Relationship Between Psychiatry and Pediatrics: A Disputatious View." Annual Progress in Child Psychiatry and Child Development. Edited by Stella Chess and Alexander Thomas. New York: Brunner/Mazel, 1968.

Etzioni, Amitai. "Modern Organizations." The Semi-Professions and Their Organizations. Edited by Amitai Etzioni. New York: The Free Press, 1969.

Fontana, V.C. The Maltreated Child. 2nd ed. Springfield, Illinois: Charles C. Thomas, 1971.

Fraiberg, Selma. "Legacies and Prophecies." Speech delivered at Smith College School for Social Work, at graduation ceremonies, August 22, 1973.

Galdston, Richard. "Violence Begins at Home." Unpublished paper presented at the annual meeting of the American Academy of Child Psychiatry in Denver, Colorado, October 17, 1970. Subsequently published under the same title in an unidentified journal.

Gelles, Richard J. "Child Abuse as Psychopathology: A Sociological Critique and Reformulation." American Journal of Orthopsychiatry, XLIII (July, 1973), 611-21.

Granger, James A. "The Abuse of Youth: The Army's Response to PL 93-247." Unpublished paper prepared for publication, Washington, June, 1976.

Helper, Ray E. "The Reluctant Samaritans." Speech delivered to the annual meeting of the American Academy of Pediatrics, San Francisco, California, 1974. Later excerpted in Emergency Magazine, March, 1975, pp. 99-100, 107.

- Helfer, Ray E., and Kempe, C. Henry, eds. The Battered Child. Chicago: The University of Chicago Press, 1968.
- Helfer, Ray E., and Kempe C.H., eds. Helping the Battered Child and His Family. Philadelphia: J.B. Lippincott Company, 1972.
- Helfer, R. E., and Kempe, C. H., eds. Child Abuse and Neglect: The Family and the Community. Cambridge, Massachusetts: Ballinger Publishing Company, 1976.
- Heyman, Margaret M. "Collaboration Between Doctor and Caseworker in a General Hospital." Social Casework XLVIII (May, 1967), 286-92.
- Johnson, Betty, and Morse, Harold A. "Injured Children and Their Parents." Children, July-August, 1968, pp. 147-52.
- Justice, Blair, and Justice, Rita. The Abusing Family. New York: Human Sciences Press, 1976.
- Kempe, C.H.; Silverman, F.N.; Steele, B.F.; Droegemueller, William; and Silver, H.K. "The Battered Child Syndrome." Journal of the American Medical Association, CLXXXI (1962), 17-24.
- Konopka, Gisela. Social Group Work: A Helping Process. Englewood Cliffs, New Jersey: Prentice-Hall, Incorporated, 1972.
- Leavitt, Jerome E., ed. The Battered Child: Selected Readings. Fresno, California: General Learning Press, 1974.
- Lehman, William J. "Suffer the Little Children: Child Maltreatment in the Military Community." Unpublished thesis, the Judge Advocate General's School, U.S. Army, 1973. "The opinions and conclusions expressed in [this referenced work] are those of the individual student author [Lehman] and do not necessarily represent the views of either the Judge Advocate General's School, U.S. Army, or any other governmental agency."
- Livingstone, John B.; Portnoi, Tikvah; Sherry, Norman; Rosenheim, Eliyahu; and Onesti, Silvio. "Comprehensive Child Psychiatry Through a Team Approach." Children, September-October, 1969, pp. 181-6.

- Lourie, Norman V., and Lourie, Betty P. "A Noncategorical Approach to Treatment Programs for Children and Youth." Annual Progress in Child Psychiatry and Child Development. Edited by Stella Chess and Alexander Thomas. New York: Brunner/Mazel, 1971.
- Lurie, Olga R. "Parents' Attitudes Toward Children's Problems and Toward Use of Mental Health Services." American Journal of Orthopsychiatry, XLIV (January, 1974), 109-20.
- McKain, Jerry L. "Alienation, Geographical Mobility and Army Family Problems." Unpublished research paper, 1969.
- McKain, Jerry L. "Child Abuse and Neglect." Unpublished paper, Fort Sam Houston, Texas, 1973.
- Miller, John K. "Child Abuse in the Military." Family, December 6, 1972, pp. 8-10.
- Miller, John K. "Perspectives on Child Maltreatment in the Military." Child Abuse and Neglect: The Family and the Community. Edited by R.E. Helfer and C.H. Kempe. Cambridge, Massachusetts: Ballinger Publishing Company, 1976.
- Moore, Wilbert E. The Professions: Roles and Rules. New York: Russell Sage Foundation, 1970.
- Murphy, Honorable Tim. "The Relationship Between the Judiciary, Prosecutors, Law Enforcement, and Probation Officers." Speech delivered at the Tenth Annual Interagency Workshop, Institute of Contemporary Corrections and the Behavioral Sciences, Sam Houston State University, Huntsville, Texas, June 13, 1975.
- National Center on Child Abuse and Neglect. Child Abuse and Neglect: The Problem and Its Management. Vol. 3: The Community Team: An Approach to Case Management and Prevention. Washington: Department of Health, Education and Welfare, 1976.
- Office of Child Development. Comprehensive Emergency Services. Washington: Department of Health, Education and Welfare, 1977.
- Office of the Adjutant General. Letter to Major Army Commands, subject: Child Advocacy Program. Letter number 608-75-2, May 16, 1975.

- Paulsen, Monrad G. "Legal Protections Against Child Abuse." Children, March-April, 1966, pp. 42-8.
- Polier, Honorable Justine Wise. "Professional Abuse of Children: Responsibility for the Delivery of Services." American Journal of Orthopsychiatry, XLV (April, 1975), 357-62.
- Pryzwansky, Walter B. "A Reconsideration of the Consultation Model for Delivery of School-Based Psychological Services." American Journal of Orthopsychiatry, XLIV (July, 1974), pp. 579-83.
- Rackley, Ray, ed. Research, Demonstration, and Evaluation Studies--Fiscal Year, 1976. Washington: Department of Health, Education and Welfare, 1976.
- Reister, Henry C., III. "Child Abuse." Present Concepts, December, 1971, pp. 3-10.
- Sattin, Dana B., and Miller, John K. "The Ecology of Child Abuse Within a Military Community." Unpublished paper presented at a meeting of the Rocky Mountain Psychological Association, Salt Lake City, Utah, May, 1970. A revised, edited version was subsequently published in The American Journal of Orthopsychiatry, XLI (July, 1971) pp. 675-8.
- Silver, Larry B.; Dublin, Christina C.; and Lourie, Reginald S. "Agency Action and Interaction in Cases of Child Abuse." Social Casework, LII (March, 1971), pp. 164-71.
- Steele, Brandt F. Working With Abuse Parents From a Psychiatric Point of View. Washington: National Center on Child Abuse and Neglect, 1975.
- Tasem, Walter M.; Dasteel, Joan C.; and Goldenberg, Erwin D. "Psychiatric Screening and Brief Intervention in a Pediatric Program Utilizing Allied Health Personnel." American Journal of Orthopsychiatry, XLIV (July, 1974), pp. 568-78.
- Thomson, Ellen M.; Paget, Norman W.; Bates, Doris W.; Mesch, Morris; and Putnam, Theodore I. Child Abuse: A Community Challenge. Ease Aurora, New York: Henry Stewart, Incorporated, 1971.
- Vernon, Glenn M. Human Interaction: An Introduction to Sociology. 2nd ed. New York: The Ronald Press Company, 1972.

- Weaver, Edward T. "Issues Related to the Delivery of Protective Services on the Local Level." Speech delivered to the National Child Abuse Conference, Atlanta, Georgia, January, 1976.
- Welton, George C. "The Infant and Child Protection Council: Background and Beginnings." Paper presented to the National Conference of Social Workers, San Francisco, California, 1968.
- White, Florine; Smith, Allen R.; and Giles, Joe H. "A Community Council for Child Welfare Services." Paper presented at the National Conference of Social Workers, San Francisco, California, 1968.
- Woolley, P.V., and Evans, W. "The Roentgen Manifestations of Unrecognized Skeletal Trauma in Infants." American Journal of Roentgenology, Radium Therapy and Nuclear Medicine, LXIX (October, 1953), pp. 413-27.
- Zalba, Serapio R. "The Abused Child: I. A Survey of the Problem." Social Work, XI (October, 1966), pp. 3-16.

APPENDIX A

Army Regulation No. 600-48, The Army
Child Advocacy Program (ACAP)

ARMY REGULATION

No. 600-48

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC, 26 November 1975

PERSONNEL—GENERAL

ARMY CHILD ADVOCACY PROGRAM (ACAP)

Effective 1 February 1976

This regulation provides policy and guidance to installation commanders on the coordination of human services directed toward promoting the well-being of children of Army families and, specifically, toward preventing, controlling, and treating child neglect and abuse. Local limited supplementation of this regulation is permitted, but is not required. If supplements are issued, Army Staff agencies and major Army commands will furnish one copy of each to HQDA (DAPE-HRL) WASH DC 20310; other commands will furnish one copy of each to the next higher headquarters.

	Paragraph
SECTION I. GENERAL	
Purpose.....	1
Objectives	2
Applicability	3
Concepts	4
Explanation of terms	5
Responsibilities.....	6
Eligibility for services	7
II. THE INSTALLATION ACAP	
Responsibilities.....	8
Functional elements	9
Child advocacy/human resources council	10
Child protection and case management team (CPCMT).....	11
III. IDENTIFICATION, TREATMENT AND DISPOSITION	
General	12
Identification	13
Medical examinations.....	14
Reporting results of medical examinations.....	15
Evaluation of maltreatment.....	16
Treatment of families.....	17
Medical records.....	18
Disposition of cases	19
Law enforcement investigations.....	20

Section I. General

1. Purpose. This regulation prescribes policy and procedures for establishing and implementing the Army Child Advocacy Program (ACAP).

2. Objectives. The objectives of the ACAP are to—

a. Develop a community based program to monitor and coordinate all programs and services that impact on children's growth and development.

b. Identify, use, and strengthen existing community resources to enhance the general welfare of children.

c. Prevent and control child maltreatment by educating and training all personnel and particularly those personnel who provide health and welfare services to military families in the command, in the recognition of the causes and consequences of child maltreatment.

26 November 1975

d. Identify, report, and manage cases of child maltreatment among Army families by—

(1) Insuring the protection, treatment, and proper management of maltreated children.

(2) Assisting parents to recognize causes of child maltreatment and to become effective parents.

(3) Insuring that command and staff personnel are aware of their responsibilities for preventing maltreatment and for identifying, reporting, protecting, managing, and treating these children.

3. **Applicability.** This regulation applies to all personnel entitled to care in Army medical treatment facilities (MTF). It does not apply to members of the Army National Guard or US Army Reserve who are not on active duty.

4. **Concepts.** a. The quality of the soldier's family life affects his performance which, in turn, affects the morale, discipline and health of the command; therefore, the growth, social development, health, and safety of children of Army families are matters of concern to commanders at all levels.

b. Family members endure the social and emotional stresses caused by the servicemember's fulfillment of the role of a soldier. Therefore, Army families, who must move frequently and be subject to unanticipated temporary absences of the servicemember, may require the services of community agencies (chap. 2, AR 608-1). The installation commander can assist families and prevent child maltreatment through an effective ACAP.

c. Although military installations and surrounding civilian communities usually offer a wide range of services for children, families and children often are unable to obtain necessary support from these agencies and institutions. The purpose of the ACAP is to function on behalf of children in relation to those services and institutions that have an impact on their lives.

d. Incidents of child abuse and neglect involving Army personnel and their dependents reflect a widespread societal problem. Humanitarian concern requires that all personnel assist in identifying and reporting endangered children and that responsible authorities intercede on behalf of these children.

e. The ACAP is a command program. Most military installations and communities already have many health and welfare resources which enable commanders to carry out this program. The ACAP provides an administrative mechanism for the installation commander to—

(1) Insure that staff personnel are aware of the special needs of children and of the community services required to supplement families' efforts in fulfilling those needs.

(2) Insure interagency, staff, and command cooperation in addressing child advocacy.

(3) Use community resources efficiently for the prevention of child maltreatment.

f. The causes of child abuse and neglect are complex. Some abuse and neglect can be attributed to parents who have psychiatric problems, relate ineffectively to other people, lack knowledge of how to be competent parents, or do not know of alternate ways to control their children. In some cases, severe family financial or other situational stress appears to play a key role. It must be recognized, therefore, that child maltreatment is not necessarily the result of willful criminal intent. Educational programs and maximal use of community resources as preventive measures should receive a high priority. In specific cases of abuse and neglect, medical personnel, those who provide social and legal services, and law enforcement personnel must be prepared, as appropriate, to assist the family, to intercede on behalf of children, and to take measures to prevent imminent or ongoing child maltreatment.

5. **Explanation of terms.** The terms below are explained as they apply to this regulation.

a. *Army Child Advocacy Program (ACAP).* An organized effort on the part of the Army to promote the growth, development, and general welfare of children of Army families by coordinating human services provided children and by interceding on their behalf when necessary.

b. *Community.* Unless otherwise identified, the military community and those civilian institutions necessary for the support of the military community.

c. *Child abuse and neglect.* The physical or mental injury, sexual abuse, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circum-

26 November 1975

stances which indicate that the child's health or welfare is harmed or threatened (Public Law 93-247).

d. Maltreatment. Abuse and/or neglect.

e. Suspected child maltreatment. A situation in which the possibility of child maltreatment is sufficient to warrant investigation by the child protection and case management team (CPCMT) but in which the evidence gained does not conclusively support the belief that maltreatment occurred.

f. Established child maltreatment. A situation in which the CPCMT, after its evaluation, determines that maltreatment did occur.

6. Responsibilities.

a. Deputy Chief of Staff for Personnel (DCSPER) has general staff responsibility for the ACAP.

b. The Adjutant General will support the ACAP with resources and technical assistance in conjunction with his other activities relating to the provision of welfare services to servicemembers and their families.

c. The Surgeon General will support the ACAP with resources and technical assistance in conjunction with his other activities relating to the provision of health services to servicemembers and their families. In addition, he will—

(1) Establish a system for collecting data on cases of child maltreatment.

(2) Supervise the medical and psychosocial aspects of identifying, preventing, and treating child maltreatment.

d. The Chief of Chaplains will support the ACAP with resources and technical assistance in conjunction with his other activities relating to the morale and morals of servicemembers and their families.

e. The Chief of Information will coordinate information support concerning the Army's ACAP.

f. The Judge Advocate General will provide legal advice in matters pertaining to the ACAP as required.

7. Eligibility for services. Eligibility for ACAP services will be determined in accordance with the provisions of AR 40-3.

Section II. THE INSTALLATION ACAP

8. Responsibilities. *a.* The installation commander will—

(1) Establish an ACAP when 2,000 or more dependents of assigned military personnel are residing on or off the installation. Consistent with the child welfare needs of the installation, an ACAP may be established on smaller installations.

(2) Designate an officer to monitor and provide staff supervision of the installation ACAP.

b. The Medical Treatment Facility (MTF) commander will—

(1) Organize and supervise, subject to the direction of the installation commander, a child protection and case management team (CPCMT) to assist in evaluation, diagnosis, treatment, and recommending disposition of children who are abused or neglected.

(2) Designate a staff member, usually a social worker or community health nurse, as a point of contact to receive and act upon all reports of child maltreatment referred to the MTF.

c. The officer assigned responsibility for staff supervision of the installation ACAP (ACAP officer) will—

(1) Direct planning and coordinating services rendered to children of eligible servicemembers.

(2) Maintain liaison with the MTF commander to insure the support of the military community in implementing the ACAP.

(3) In conjunction with the MTF commander and the provost marshal/security officer, insure that all reported incidents of child maltreatment receive immediate action.

d. The staff judge advocate will provide legal advice to the commander and to ACAP personnel. Such advice will include—

(1) Representation on the CPCMT to insure that the team's activities and staff procedures conform to the law.

(2) Guidance on any requirements that medical or other personnel have to report incidents of maltreatment to government/civil authorities.

(3) Guidance on the scope of authority that state officials may exercise over military personnel and dependents who are residing both on and off the federal installation. Specifically, the SJA should advise the commander and ACAP personnel on the legal requirements of any constraints on—

(a) Compulsory medical examination and treatment.

(b) Removal of child from the home.

(c) Placement of child in a foster home or institution.

(d) Hospitalization.

e. The installation chaplain will provide professional assistance and will insure that the members of the staff of Family Life programs recognize, assist, and refer for additional help families in serious stress.

9. Functional elements. The installation ACAP will consist of two functional elements. (See fig. 1.)

a. Planning and coordination of existing child and family social services and development of the educational elements of the ACAP will be accomplished by a child advocacy/human resources council composed of staff personnel designated by the installation commander.

b. Management of cases of maltreated children will be accomplished by a multi-disciplinary child protection and case management team (CPCMT) functioning under the supervision of the MTF commander.

10. Child advocacy/human resources council. a. *General.* Rather than forming an additional council, the ACAP functions should be assigned to an existing council that addresses Human Resources programs (sec II, chap 2, AR 608-1 and AR 600-85, to be published).

b. *Organization.* Chairmanship, frequency of formal meetings, and composition of membership will be determined by the installation commander. In coordination with the ACAP officer, the chairman will formally task council members or their respective agencies to take necessary action to accomplish the functions in c below.

c. *Functions.* To assist the commander to exercise his overall responsibility for the installation child advocacy program, the council provides

guidance and assistance to installation staff personnel and agencies. The council will—

(1) Assess the special needs of children of military personnel residing on the installation and in the surrounding community.

(2) Identify deficiencies in services provided for the physical, educational, moral, and social development of children.

(3) Establish and publicize reporting procedures for all incidents of child maltreatment and assist personnel in reporting these incidents.

(4) Establish, as appropriate, parent effectiveness training and/or family life education as important elements of the program for preventing the maltreatment of children. (See DA Pam 165-7-1.)

(5) When feasible, develop and assist in implementing standard health evaluation of children under 5 years of age.

(6) Insure, in conjunction with the MTF, that programs effectively provide appropriate assistance, treatment, and followup service to families identified as maltreating their children.

(7) Establish and monitor, where feasible, a foster home program in conjunction with existing local foster care programs.

(8) Establish and monitor a postwide educational effort to—

(a) Inform all personnel of action needed to enhance the general welfare and to prevent maltreatment of children of Army personnel.

(b) Stress the need for a widespread willingness among personnel to report incidents of child maltreatment.

(c) Emphasize the importance of total community involvement in the installation ACAP.

11. Child protection and case management team (CPCMT). a. *General.*

(1) The installation commander, with the advice of the MTF commander, will appoint a multidisciplinary CPCMT to manage the cases of children and families coming to the attention of the MTF because of maltreatment. The MTF commander will supervise the CPCMT, insuring that emphasis is placed on establishing and preserving an emotionally healthy, nonabusive family rather than on removing the child and punishing the parents.

(2) The ACAP officer will be kept informed of CPCMT activities and will support its efforts by serving as the point of contact for staff coordination.

b. Membership

(1) The CPCMT will consist of the following professional personnel: pediatricians, psychiatrists, psychologists, social workers, nurses, and lawyers.

(2) At the discretion of the MTF commander, law enforcement personnel, civilian child protection workers, chaplains, occupational therapists, and other personnel who may contribute to the evaluation, treatment and progress of the case management process may be included in the membership.

c. Functions. The CPCMT will—

(1) Identify problem families, and will protect and treat the maltreated child and his family by—

(a) Obtaining medical, psychological, and social evaluations of children and parents coming to the attention of the MTF because of child maltreatment.

(b) Assisting with the diagnosis, family appraisal, and treatment of families referred to the team from all sources. Treatment in a MTF

will be provided only to parents who volunteer for treatment.

(c) Assisting in establishing the existence of child maltreatment through medical, psychological, and social evaluations.

(d) Completing and forwarding the case management summary (para 18b).

(2) Make recommendations to the ACAP officer regarding—

(a) Requirements for protective custody of maltreated children.

(b) Alternative courses of action when parents refuse to volunteer for, cooperate in, or follow a recommended treatment plan.

(c) The requirement for intervention by a court or a law enforcement agency in specific incidents.

(d) The need to notify a gaining installation or civil authorities when an active case is terminated because a family is relocating.

(3) Identify and recommend corrective action to the Child Advocacy/Human Resources Council concerning conditions that contribute to child abuse and neglect and that impede reporting, treatment, and disposition of maltreated children.

(4) Use and coordinate available resources (military and civilian) to treat children and families referred to the MTF.

Section III. IDENTIFICATION, TREATMENT, AND DISPOSITION

12. General. Community agencies should maintain close liaison with one another in order to help identify and refer children who have been maltreated. Clearly defined procedures must be established to insure prompt notification of law enforcement agencies when serious maltreatment is involved.

13. Identification. *a.* Military and civilian personnel are encouraged to report all incidents of suspected child maltreatment to the designated MTF point of contact or military/security police. When persons who are providing statements pertaining to cases of suspected child maltreatment make an expressed request that their involvement be held in confidence and when they can be granted confidentiality under the provisions of AR 340-21, then their statements will be so identified in case records.

b. Initial identification of child maltreatment usually will be made by medical personnel. Public and private social welfare agencies, school officials, chaplains, child care centers, and law enforcement officials may also identify and refer these cases.

14. Medical examinations. *a.* All cases of alleged child maltreatment will be referred to the MTF for examination, treatment, and evaluation by the CPCMT.

b. All cases will be carefully recorded by the attending physician. This record will include a description of the child's general appearance, the location of bruises, contusions, fractures, and other injuries. A detailed account of how the injuries were reported to have occurred will be obtained from the person who brings the child to the

MTF. The information will be recorded on appropriate medical forms, filed in the appropriate medical records (para 18), and maintained in accordance with AR 40-400. Photographs, in color if possible, should be made of the injuries.

c. The possibility of child *abuse* should be considered by the examining physician when—

(1) There is an inadequate or inappropriate explanation of how the injuries were sustained.

(2) Multiple fractures are present.

(3) Multiple or recurrent injuries (e.g., burns, subdural hematomas, fractures) exist.

(4) A child is dead on arrival at the MTF.

(5) Reports or complaints of sexual abuse are made.

d. The possibility of *neglect* should be considered when—

(1) Young children are left unattended.

(2) Advanced untreated diseases are diagnosed.

(3) Unsanitary living conditions exist.

(4) Emotional, moral, or social deprivation becomes a matter of public knowledge.

(5) Unexplained incidents of "failure to thrive" are diagnosed.

15. Reporting results of medical examination. a. The attending physician will insure that prompt and proper notification of results of the medical examination is made to the designated MTF point of contact (para 8b(2)).

b. The MTF commander or his designated representative will determine if the reporting of the incident to law enforcement officials is warranted. If so, the office of the provost marshal/security officer will be notified immediately.

c. When the MTF commander requires assistance in making an immediate response or determines that a case requires assistance from other agencies, he will notify the ACAP officer. This officer will task the appropriate agency with taking necessary action.

16. Evaluation of maltreatment. As part of the evaluation of child maltreatment and as an integral part of the ACAP, the case management team will—

a. Substantiate maltreatment.

b. Plan appropriate intervention.

c. Monitor treatment, to include followup work after the treatment regimen is completed.

d. Recommend disposition of all referred cases.

17. Treatment of families. In addition to traditional treatment methods, such as individual and group therapy, social casework, and environmental manipulation, other strategies for intervention may include the use of—

a. Trained volunteers,

b. Parents anonymous,

c. A telephone crisis "hot line",

d. A crisis nursery,

e. A therapeutic day care center, and

f. An educational program, including family life and parent effectiveness training.

18. Medical records. a. A medical record will be prepared for each individual treated or evaluated for child maltreatment. A special outpatient treatment record may be prepared and coded as a *special category record* in accordance with paragraph 5-10b, AR 40-400. Access to these records will be given in accordance with the provisions of AR 40-42.

b. A case management summary of established cases of child maltreatment will be prepared using DA Form 4461-R (fig. 2). DA Form 4461-R will be reproduced locally on 8 by 10½ in paper. A copy will be forwarded to: Commander, US Army Health Services Command, ATTN: HSOP-PR, FT Sam Houston, TX 78234.

19. Disposition of cases. When evaluating and recommending disposition of cases involving child maltreatment, the CPCMT, with the SJA representative in attendance, should address the following—

a. Establishment of child maltreatment.

b. Appropriate treatment of the maltreated child and his parents (para 17).

c. Reporting or referral to civilian authorities.

d. The need for formal investigation by a law enforcement agency.

e. Recommending removal of child from its home.

f. Recommending expulsion of family from the military installation in order to place the family within reach of competent civil jurisdiction.

g. Referral of the family to a gaining installation, or civilian community, upon reassignment, transfer, ETS, or retirement of servicemember.

h. Closure of case.

20. Law enforcement investigations. Law enforcement investigations of child maltreatment by CID or military/security police will be conducted in accordance with AR 190-30 and AR 195-2, as appropriate. Military police reports will be completed and processed in accordance with AR 190-45.

26 November 1975

113

AR 600-48

The proponent agency of this regulation is the Office of the Deputy Chief of Staff for Personnel. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) direct to HQDA (DAPE-HRL) WASH DC 20310.

By Order of the Secretary of the Army:

Official:

PAUL T. SMITH

*Major General, United States Army
The Adjutant General*

FRED C. WEYAND

*General, United States Army
Chief of Staff*

DISTRIBUTION:

To be distributed in accordance with DA Form 12-9A requirements for AR, Personnel General.

Active Army: C (Qty rqr block no 384)

ARNG: None.

USAR: D (Qty rqr block no. 385)

SUGGESTED INSTALLATION ORGANIZATION CHART

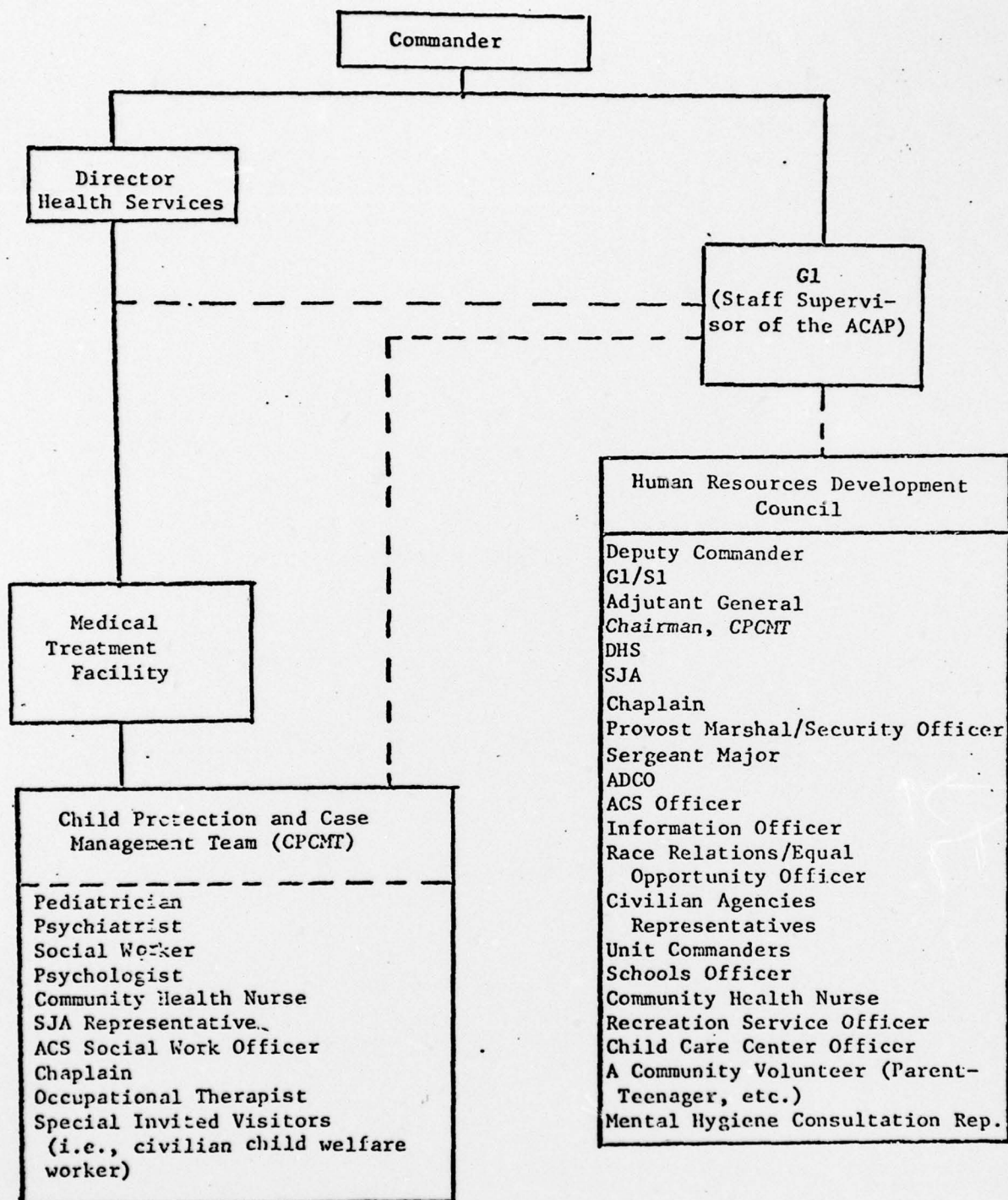


Figure 1

CHILD MALTREATMENT INCIDENT CASE MANAGEMENT SUMMARY				1. DATE AR 600-48	
For use of this form, see AR 600-48: the proponent agency is ODCSPER.					
2. NAME (Last, First, Middle Initial)			3. SEX	4. AGE	5. RACE
					6. RELIGION
7. FMO	8. SSN (Sponsor)		9. SPONSOR'S NAME (Last, First, Middle Initial)		
10. SPONSOR'S ORGANIZATION AND DEPARTMENT			11. HOME ADDRESS (Include ZIP Code)		
12. TYPE OF INCIDENT <input type="checkbox"/> PHYSICAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> OTHER (Specify)			13. <input type="checkbox"/> INCIDENT CONFIRMED <input type="checkbox"/> INCIDENT SUSPECTED		
14. SUMMARY OF INCIDENT (Who, what, when and how)					
15. RESULTS OF MEDICAL EXAMINATION					
16. SUMMARY OF ACTION TAKEN					
16a. NAME AND ORGANIZATION OF INDIVIDUAL COMPLETING FORM				16b. SIGNATURE	

APPENDIX B
Common Resources

APPENDIX B

Alcohol and Drug Abuse Counseling Center
American Red Cross
Army Child Advocacy Program Council (ACAP Council)
Army Community Service
Army Health Nurse
Chaplains
Child Care Center/Post Nursery Personnel
Child Protection and Case Management (CPCMT) (CPC) (SCAN Council)
Commander of Sponsor of Abused Dependent
Community (local, civilian) Child Protection Service Agency (DPW) (SRS)
Community (local, civilian) Family Courts
Emergency Room Personnel
Family Therapist (on hospital staff)
General Staff Officer (at Post level)
Hospital Administrators
Hospital Commander
Law Enforcement Personnel (policemen and investigators)
Mental Health/Hygiene Clinic
Pediatric Clinic Nurses
Pediatric Ward Nurses
Pediatricians (on hospital staff)
Physicians (non-pediatric, on hospital staff)
School Administrators

School Nurses

School Teacher

Social Work Services (on hospital staff)

Staff Judge Advocate (lawyers)

U.S. Magistrate (on-Post, civilian, Federal "judge")

Well Baby Clinic Nurses

APPENDIX C
Survey Questionnaire

The following questionnaire will take about 20 minutes to complete.

I am interested in learning your personal opinion about various aspects of child abuse and neglect case management in the military community. By "child abuse and neglect", I am referring to the physical or mental injury, sexual abuse, or maltreatment of a child under the age of eighteen by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened.

By "case management", I am referring to any action taken by anyone in authority subsequent to the initial discovery that child abuse and neglect (or suspected child abuse and neglect) has taken place.

"Hospital" refers to an Army Medical Treatment Facility.

Personal anonymity is guaranteed; your responses will be combined with nearly 400 others. Taken together, they will form a data base for a Master's thesis.

Most questions will call for one or two responses. When appropriate, please refer to the separate list of PERSONNEL CATEGORIES when answering. Use the code letter that matches your desired response.

Thank you for participating in this survey.

Jack Martin

1. From the list provided, find the personnel category that best describes you at this time. Mark the code letter of that category here.

2. Have you had any personal experience with a child abuse and neglect case management situation in the military community?

circle one: YES NO

3. In your opinion, does the Army currently have a highly effective procedure for dealing with instances of child abuse and neglect?

circle one: YES NO Don't know

4. Should the Army be concerned with a multidisciplinary (professional team) concept in its approach to child abuse and neglect case management?

circle one: YES NO Don't know

If NO, which personnel category should assume total responsibility?

1st choice: _____ 2d choice: _____

5. If a general problem arose in a child abuse and neglect case management situation, to which personnel category would you probably turn for advice/assistance?

1st choice: _____ 2d choice: _____

6. Which personnel category should set the limits of your professional involvement in child abuse and neglect case management?

1st choice: _____ 2d choice: _____

7. I am generally satisfied with the role my personnel category plays in child abuse and neglect case management.

circle one: TRUE FALSE

If FALSE, how would you alter its present role? _____

THIS PAGE IS BEST QUALITY REPRODUCIBLE

FROM COPY FURNISHED TO DDC

8. Do you feel the members of your personnel category are in competition with other personnel categories in the area of child abuse and neglect case management?

circle one: YES NO Don't k

If YES, with which other personnel categories?

1st choice: _____ 2d choice: _____

9. Members of which personnel category seek advice/assistance most of from members of your personnel category?

1st choice: _____ 2d choice: _____

10. In child abuse and neglect case management situations, in which personnel category do you have most confidence in judgement?

1st choice: _____ 2d choice: _____

11. Does the "collective nature" (joint decisionmaking) of child abuse and neglect case management decisions ever disturb you as an individual?

circle one: YES NO Don't k

If YES, please explain: _____

12. Which personnel categories do you feel are best qualified to have overall responsibility for child abuse and neglect case management?

1st choice: _____ 2d choice: _____

13. Which personnel category do you feel is least qualified to participate in child abuse and neglect case management decision making?

1st choice: _____ 2d choice: _____

14. Which personnel categories do you feel are best trained to handle child abuse and neglect case management situations?

1st choice: _____ 2d choice: _____

15. Which personnel categories do you feel are presently most influential in child abuse and neglect case management decision making?

1st choice: _____ 2d choice: _____

THIS PAGE IS BEST QUALITY PRACTICABLE
FROM COPY FURNISHED TO DDG

16. Which personnel categories do you feel should be most influential in child abuse and neglect case management decision making?

1st choice: _____ 2d choice: _____

17. In a child abuse and neglect case management situation, consultation with which personnel category would be most valuable to you?

1st choice: _____ 2d choice: _____

18. In general, are the members of your personnel category willing to cooperate and work with the members of other personnel categories?

circle one: YES NO Don't know

19. In your opinion, which personnel category is most likely not to deliver the child abuse and neglect case management services it should?

1st choice: _____ 2d choice: _____

20. Do you feel you are personally qualified to participate in child abuse and neglect case management decisions?

circle one: YES NO Don't know

21. In general, do you feel the members of your personnel category like to work for the members of other personnel categories?

circle one: YES NO Don't know

If YES, which other personnel categories?

1st choice: _____ 2d choice: _____

22. Did you receive any instruction regarding the child abuse and neglect subject area in any of your military training? circle one: YES NO

If YES, when (year)? _____
where (what school/course)? _____

approximate time devoted to subject: _____

23. Did you receive any instruction regarding the child abuse and neglect subject area in any of your professional training? circle one: YES NO

If YES, when (year)? _____
where (what school/course)? _____

approximate time devoted to subject: _____

24. In your opinion, is military rank (or civilian status) more influential in the child abuse and neglect case management decision making process than is a comprehensive knowledge of the subject area?

circle one: YES NO Don't know

25. The members of your personnel category are most likely to share specialized knowledge in the child abuse and neglect case management area with the members of which other personnel categories?

1st choice: _____ 2d choice: _____

OR CHECK ☐ Specialized knowledge is likely not to be shared.

26. What is the title and/or author of the best publication you have read on the subject of child abuse and neglect in the past year?

(or brief description) _____

OR CHECK ☐ I have not read on the subject in the past year.

27. If you were in charge of the child abuse and neglect case management decision making process, list all personnel categories you would routinely exclude from deliberations.

28. Are you a member of the CPCMT? YES NO

29. Are you a member of the ACAP Council? YES NO

30. Are you a parent? YES NO

THIS PAGE IS BEST QUALITY PRACTICABLE
FROM COPY FURNISHED TO DDG

31. What is your age? _____
32. What is your military rank (or civilian status)? _____
33. How many years have you been professionally associated with the military? _____
34. How many years have you been practicing your profession? _____
35. In your opinion, what is the goal of child abuse and neglect case management in the military community?
- _____
- _____
- _____
- _____
- _____
- _____

36. What are your personal suggestions for improvement in the Army child abuse and neglect case management program? Please mention anything about the subject you feel would be of value.
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Thank you, again, for participating in this survey.

PERSONNEL CATEGORIEScode

- A Alcohol and Drug Abuse Counseling Center
- B American Red Cross
- C Army Child Advocacy Program Council
- D Army Community Service
- E Army Health Nurse
- F Chaplains
- G Child Care Center/Post Nursery personnel
- H Child Protection and Case Management Team
- I Commander of sponsor of abused dependent
- J Community (local, civilian) child protection service agency
- K Community (local, civilian) family courts
- L Emergency Room personnel
- M Family therapist (on hospital staff)
- N General Staff Officer (at Post level)
- O Hospital administrators
- P Hospital commander
- Q Law enforcement personnel (policemen and investigators)
- R Mental Health/Hygiene Clinic
- S Pediatric Clinic nurses
- T Pediatric Ward nurses
- U Pediatricians (on hospital staff)
- V Physicians (non-pediatric, on hospital staff)
- W School administrators
- X School nurse
- Y School teacher
- Z Social Work services (on hospital staff)
- AA Staff Judge Advocate (lawyers)
- BB U.S. Magistrate (on-Post, civilian, Federal "judge")
- CC Well Baby Clinic nurses
- DD Other (please specify in each instance)